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Dimensional Psychology/Therapy

Today in the field of mental health there are numerous observed categories that define mental illness as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Each of these categories have a specific group of identifiable features and should a client be observed to manifest a certain number of these features, then it is upon this cluster that a diagnosis is made.

In a clinical setting this is accomplished by a team of mental health practioners who employ various assessment tools including interviews, testing materials, a review of the client's social history, as well as direct observations in various social settings such as in the home, in school and in the community. The team is usually made up of a psychiatrist as the team leader, a psychologist, and a clinical social worker. The benefit of this approach is that it provides the professionals with the security of the team as the diagnosis establishes the foundation, the structure, the medication, and strategies to provide the client with a series of therapeutic interventions. This allows the clients to have the guidance of coordinated assistance in their effort to explore and re-order their knowledge of themselves and their social circle all of which hopefully results in an improvement in their life.

In my experience working directly with clients in their home and in the community it appears that at times there is a weakness in this approach of the system of care as it leaves the client out of an active role in the process of determining their diagnosis. If the client is a child or a youth the therapists rely heavily on the reports by others such relatives, parents and teachers. Given time and budgetary restrictions there is very limited direct observation by the social worker in a visit to the school, in the home, and in the community. If the clinic has the budget for the materials there may be testing by the psychologist that can help the team in the determination of the diagnosis. The outcome of the information being largely sourced from other than the client sets up a disconnect for the client. This approach is an outcome of the influence of our culturally dualistic rationality that systemically supports and sets up a disruptive tension between the roles: the dominance of the professionals and the subordination of the client.

All too often, the therapist being acculturated, is hardly conscious of the uneven nature of the culturally promoted hierarchical relationship and as a result may misinterpret their findings on the way to forming a diagnosis and thereafter a therapeutic relationship. Of course the client struggling with the acculturation as exhibited from their behavior is thereby operating from a subconscious influence, perhaps in some form of rebellion against the one-sided nature of most relationships when interacting with an adult. This tension often follows the client into adult services

The client/therapist relationship is further complicated as the therapist is undermined due to certain systemically imposed restrictions in establishing a viable relationship. One such way is that due to liability issues most of the therapy is conducted in the therapist's office, removed from the normal social dynamics that most relationships require. In short they are able to talk about socialization skills, but rarely can provide an interactive role modeling through their relationship with others. Another severe limitation is in regards to the amount of time that the client and the therapist can spend together. The client comes to therapy usually once a week and for no more than 45 minutes. Another limitation is that if the family is involved they are allocated one meeting a month

also for about 45 minutes. Between these meetings there is usually very little contact if any between the therapist and client and their family and so they are on their own between sessions. Is this reasonable?

If medication is prescribed by the psychiatrist it is not unusual for the medication to take four to five weeks to gradually take effect. So while the client and the family is informed of this, none-the-less they may be under the impression that the client is really medicated and when there is initially little to show for it they may increasingly come to lose confidence in the value of medication. By not seeing any immediate results they may become lax and inconsistent in providing the medication to the client. This situation is often not detected by the therapeutic team, which complicates the situation drastically. Another undermining aspect of medication is in regards to side effects, which also was likely reviewed, however the parents being lay people may not have the experience to be sensitive to them as they manifest. When these side effects take place they often overwhelm the benefit of taking the medicine. The way the system handles this is to rationally present the "reality" that prescribing medication is a hit and miss process, often requiring many changes in prescriptions until one works. Parents and clients hear this and should this actually be the way it goes for the client, it is entirely understandable how the client who is suffering from their illness and now also suffering from the effect of the medication can lose trust in the whole process.

While the above relates to the team's interaction with a child or youth it also relates to their interaction in adult services. However the relationship is even more restricted as there is often limited or no input from the client's family and social circle. In regards to the client's family, if any, they usually are also seriously dysfunctional and as a result they can provide little if any support between therapy sessions and often are triggering the client's behavior making it difficult for the client to practice any interventions provided by the therapist. By the way this is also the case with children and youth; the dysfunction of the family constantly reinforcing the tensions that cause mental illness.

I also feel that there is a lot of imposed pressure on the client, as the client is asked to trust the therapeutic team without any real basis of experience for this expectation. The difficult question is, what support does the client really have between office visits? It seems that the answer is usually just themselves and their supposed ability to integrate the proposed interventions, whether through medication and/or verbal input from the therapists. But then doesn't the effectiveness of the verbal input depend upon the client's ability to understand auditory input and to practice and integrate the interventions in such a way that their life is improved? How can they really do this on their own? So, then I wonder why a neuro-psych. report is not a pre-requisite requirement for each client as this would provide many of the answers to the client's ability to understand and process information in general. The information from such a report would very likely be invaluable to the therapeutic team, as it would assist them to tailor their input specific to the client. Specifically because therapy is almost completely verbal is there not then a serious consequence should the team not yet or ever know if the client is a visual, auditory and or experiential learner? This means that the client may struggle to or can't process the input by the therapists using largely verbal interaction. Well, this mounts to a chasm over which there may never be a bridge. With all of the above, I feel

that there are still more variables that need to be addressed which opens this discussion to the relevancy of this article

As there are also numerous therapeutic modalities that can be integrated into the therapeutic engagement with the client, the decision of which or which ones are to be used is solely the therapist's decision, again leaving the client out of the decision-making process. In both the setting of the diagnosis and the choice of modality(s) the question might be raised that if the client was provided a degree of therapeutic education for a few weeks before a diagnosis is established would they not be able to provide some relevant insights to the process of the team making decisions given that the client is the one experiencing the mental illness?

There are other severe limits on the therapist's scope of practice. There are innumerable factors that the therapist has no influence over. Specifically genetic and cultural factors. This article will strictly focus now on the cultural aspect of the client's life. So, would it be helpful to include the cultural context that undermines the client's ability to function? In part this would be discovered by including an exploration of the following: What influence does one's culture have on any individual's ability to cope? Certainly each culture is unique in the way it influences the following factors: The emphasis on self or community. The workload at school if the client is a child or if an adult in the environment of their employment. Adults face innumerable pressures that can quickly escalate to be overwhelming such as the increase of the cost of rent, food, transportation, childcare, clothing, health care, utilities, entertainment, and communication, Then there is also the factor of whether the client is in a dominant or subordinate social category. Further critical factors are also relevant. What about the client being able to obtain the skill levels sufficient to live as a participating member of society, or being able to be free of unreasonable demands, or whether one is able or disabled and how they are treated, and whether a person and their family live in a safe neighborhood. Then there are factors that include what degree is change taking place and given the limited level of adaptability of the client due to their mental illness, to what degree is there an array of support systems and services to ease the transitioning. Certainly then the depth of these cultural factors are a powerful influence on anyone's mental health. All of these factors contribute to the degree of stress and anxiety with which the individual has to cope.

Now, for the adult clients, questions arise: "What can I do about all of these things? I have to work. I have to spend time with my family. I don't understand my children. My spouse is never satisfied. So what about me? " All valid inquiries and yet is it reasonable for the therapist to be able to help the client to seek and thereby explore answers to these culturally influenced questions? Does the therapist even have answers for themselves?

So, I'd like to introduce a concept that moves from the generalizations of culture's influence on the individual's mental health to an investigation of what is a Psychological Dimension, the understanding of which provides one with the foundation of grasping the significance of Dimensional Psychology/Therapy. In looking at the world's cultures it's fairly obvious that each is distinct. Each culture of humanity may be viewed as a dimension in and of itself. How so? Why, starting with each culture's unique language, dress, food, music, sports, social mores, etc. Yes, each culture as a dimension of human groupings may then be viewed as having a distinct personality associated with its own

name. Even just as in a stereotypical manner let's take European countries for instance. Each of the countries of Europe has their own personality. The French know the personality of Germans who know the personality of Italians who know the personality of Spaniards…each knows the cultural personality of all their neighbors. Like the person known as Jacque is French and as a person of the French Culture the stereotype provides readily accessible features. It's all so obvious if we just focus on only one factor and that being the food that Jacque eats. To me nothing defines a culture more than their food. So now let's get a feel for Psychological Dimensions.

To me any DSM diagnosis is an Icon for a psychological dimension in which the client lives. "Oh, he's bi-polar." "Oh, she's borderline." Yeah, as if each diagnosis is the person's real name. Each name creates its own stereotype and the person is viewed as if "From There," like someone who is French comes from the France, being of the French Culture, or I would say of the French Dimension. But how to get to really know the French culture? Of course just reading about France would be interesting, but it would only be a very superficial knowledge being without any personal experience in living in the French cultural dimension. So, if I want to know more about being French, I would go to France and maybe tour or even live there for a while. Should I learn how to speak passable French my experience would probably have greater depth. If I learned how to cook French food, well, this would just open so much more to my time in France. Should I be able to find employment in France, well, wouldn't that just increase my experience? Should I even have the ability to form friendships with French people of all ages, wouldn't I then really have immersed myself and the advantage of this would be I might really have insight into the French culture. This series of engagements might then allow me to fully get French humor. At this point I would have "arrived."

I have to wonder if there is something to this in order to form an analogy resulting in the therapist increasing their effectiveness. I mean does or does not the therapist have the direct lived-experience within the diagnosed dimension in which the client lives whether through living with or have lived with a person who has a specific diagnosis or by now living as a high functioning person with this specific diagnosis?

Most of the time it seems that the therapist's knowledge has to be largely from a cognitive foundation resulting from their academic study. Even if they have suffered from any one category of mental illness they are all too specific to be generalized in their practice. However, this is exactly what is expected. In my experience, each dimension of mental illness is as different as any two snowflakes. All therapists of course have come through their own mental issues, just like the rest of humanity does as we experience the normal cultural stressors that somehow most of us have learned to manage. From these manageable personal experiences therapists come to be expected to have the sensitivity to have insight into the whole spectrum of mental illnesses. While having a base of management skills these skills would not necessarily translate into having the experience of living with unbridled chaotic unmanageable emotional currents that can rise up within another category of a diagnosed mental illness.

Even if a percentage of therapists have the lived-experience of mental illness, if they haven't accessed and experienced the ups-and-downs of various systems of support through therapy they would not have this experience as a foundation of their practice. However, should they have a specific diagnosis and had received therapy this would be extremely beneficial in their practice. However their experience and the attributed benefit

fits most closely to the type of diagnosis and the modality of delivery that they received. Believing this will be a sufficient foundation to help people with other diagnosed mental illness is like believing that because a person plays the quarterback position in football we can expect them to have the ability to play any position. Speak with any football player and they would reveal that this is not reasonable. Then what an unreasonable position the therapist is being put in when they are expected to be able to "play the field" of diagnosed mental illnesses.

What about seeing through someone else's eyes? Hmm. Then before a diagnosis is made or accepted, would it not be helpful and allow the therapy to be more effective should the therapist be able to step into the client's world for a while. Would there be a benefit from the insight into the psychological dimension by including a period of inter-personal experiences, which would permit the client to be the guide into their lived dimension and from this be encouraged to have an active role in the development of their diagnosis?

However, at this time this isn't allowed for a professional. No going into the client's inner world! This is probably a fairly wise limitation for there is no knowing if one can find their way back from the dimension, which is initially unknown and definitely alien. And, who knows if the client can even find their way back to the therapist's dimension in the first place.

Of course each of us then lives within our own psychological dimension, from which we have points of sharing and it is in this specific area of sharing that we feel comfortable in order to call this Reality. This part that overlaps is at least our common grounding. Not so with the client. There is the "normal" reality with all of its segments of interrelating dimensions, but then for the client they also live in more reclusive manner such that their dimension is only faintly connected to the "normal" reality and at other times completely disconnected. So somehow bringing the client more into the "normal" reality is kind of the sought after outcome that defines therapy. Well, isn't this the whole point of therapy? To somehow encourage the client to spend more time in what we call our reality? Isn't it in our shared dimensional segments that we agree is reality, the location of mental health? Ah. No, not really. Perhaps more accurately therapy is about helping a person to coordinate their dimension in such a manner that they can moderate the tension that they experience both within their psyche and the apparent discomfort others may feel. This may be sufficient or it may really be about the mental illness of society and assisting society to broaden its perspective of differences so that it doesn't cause such painful reactive behavior. A great example is the shift in the area of gay marriage and the reduction of stress this allowed. However it took a lot of people and their families to open their minds and realize that, hey, differences are not to be feared. Of course there is a segment of society that still promotes homophobia.

So then, tuning into Dimensional Psychology may be instructive in how anyone dimension in which we live renders us as the identity of its manifestation. This would mean that we are under its influence so much so that it strongly impacts our identity, thus our personality and the manner in which we filter our experiences.

As far as expanding the boundaries of the therapist's relationship with the client, it's kind of interesting that in our personal lives don't we hazard life by engaging in relationships in which the process of combining aspects of our dimensions form an extension of reality that is largely unknown anyway. We may assume, and perhaps we

have to, that the other person is knowable and while different in some ways, we can still feel a commonality that is somehow reaffirming and which attracts us to them. Or mostly so. At least enough to be open to being intimate in what we share together.

Here's something to look at. Of those of us who have children or even only just having parents, haven't we all taken a blind step into a relationship with a completely unknown person? What do we know of our parents or our children at birth? Of course we parents believe that we know so much more and see deeper into our children's lives as they grow-up then they will ever see of our lives. We see them nursing, on the changing table, we see them in playgroups, engaging in hobbies and sports. What? Oh yeah, you're right. We all too often don't see them in their engagement in school and or as they enter into social media and its expanding dimensions. But what do they actually ever see of us? Not in our intimate relationship with our spouse or mate. Not when we are at work. They have no idea of our lived-childhood and definitely while they may experience the outcome of our unresolved issues, they have no way of gaining insight into what those issues are. Therefore, they as children do not have the context to manage what they experience of us when we come home from work in any number of moods. So, our dimension and their dimension are intermingled in certain ways and completely separate in other ways. Do we know this consciously? Probably not.

So Dimensional Psychology/Therapy is an opening to a critical aspect of relationships and relationship building between the client and the therapist without which we all are pretty much in the dark as to what is really going on. We are currently operating outside of the context of ourselves and them. Unless they know about our dimension (our context) how can they properly process their experience with us? This is just as valid in our experience with them. Without this taking place I feel that what we are doing, more-or-less, is being forced to unknowingly engage in Closure, a term for a psychological perceptual insertion that fills in for some thing missed, a leading cause of misunderstanding. For example, we do closure all the time when we are reading. To speed up the processing of words, to keep up with the flow, our minds take a processing shortcut by taking only a visual snapshot of the first few letters of a word that we are reading and in context of what we are reading the mind provides the closure by presenting the reader with the visualization of the whole word. This is why we occasionally misread a word as the mind's mistakenly supplied a word that doesn't fit the context of what we were reading. When this happens we go back a few words and find the proper word that fits the context. This misreading happens to words that each starts with the first few letters and are about the same length. An example of this might be the words "exceptional" and "experiential." We wonder, "How could I have misread this word?"

Another example of a type of Closure takes place when we are in a conversation with someone and they say something that catches our attention. While we are ruminating over that "something" the other person continues to speak. When we turn our attention back to the conversation of which we missed the dialogue that continued while we were thinking about what had been said, the mind attempts to help us out by providing the Closure by inserting dialogue that seems reasonable to fill in the blank space. What is interesting is that we are completely unaware of this dynamic. To me, what is disturbing relates to how we actually feel and believe that what the mind substituted was actually the dialogue that we missed out on. That's why so often people are saying, "That's not

what you said," "Yes it is!" or That's not what I said." These examples are a form of Incorrect Closure.

I would like to suggest that this intrusion of Closure may be a part of what we are unconsciously doing in our relationships that results in misunderstandings of various intensities. This influence of Closure is not with just misreading a word or in what is being said, but in our lack of awareness that we are constantly trying to make sense through our way of thinking about something that we are experiencing with another person who is simultaneously experiencing life in their own dimension, just as we are. It's exhausting! This may be as serious as me speaking English to a Spanish only speaking person while both of us are believing that we are communicating in our native language. Such a situation appears ludicrous. However in my experience unless the conversation is strictly factual and not about what we believe happened or about feelings, our interpretation of what is being said as it goes through our personal experiential filtering mechanism and leads to incorrect closure creating miscommunication at a rather high degree of occurrence. These "spaces" in such a level of relating can become more and more confusing and discouraging as the relationship moves on. As this continues likely from birth the stress associated with "not being heard" and "not hearing what was said" may in a way be one of the core sources of mental illness.

Here's another analogy. When we are exhausting ourselves physically over an extended period of time, like what occurs with parents taking care of a newborn child and yet the parents have to keep functioning, their immune system begins to struggle and they often suffer from a minor or more severe physical illness. Now, the psychological immune system, usually called our Defense System, functions in a similar manner, and becomes more activated by extended periods of stress also leading to a state of exhaustion, which then causes not a physical illness necessarily, but an illness of the mind. This may appear to be what we call normal; that being the parent's tempers become frayed, their patience declines, and their ability to be supportive begins to evaporate, etc. While these are not features of any one diagnosis, they are none-the-less general features that show the signs of a weakening in the area of mental and emotional discipline (holding it together) and may weaken to such an extent that what has been a mild or nearly unidentifiable irritant may become inflamed. An example: For new mothers, experiencing continued stress in taking care of a newborn may develop into post-partum depression. In men, being physically tired from long nights with the newborn and emotionally overwhelmed may possibly develop into issues of anger management, etc. The vice constricts during the first many months of having a baby and all of this affects not only the parents but the baby as well and their siblings.

So, Dimensional Psychology/Therapy suggests there is a benefit should the therapist be not only empathetic, but to have a direct lived dimensional experience with the types of diagnosis with which they are assigned so they can anticipate these outcomes and have the personal experience to share with the client as they go through the challenges of therapy. But is this really possible given the current standards of practice? Unlikely. So what's the point of this exercise in becoming familiar with the concept of Dimensional Psychology/Therapy? Well, we might generally agree that having a lived experience with the mental illness might provide a firmer foundation for the practice of therapy. Hopefully, this being so, then a possible and realistic pathway to this possibility is what now follows.

This suggested pathway requires some depth of insight as to the benefit of recruiting some therapists who also have a direct lived experience with the types of mental illness with which they will be assigned. To me, a more functional mental health clinic would be populated with therapists who experience(ed) the specific illness and through their personal struggles and achieved growth have become sufficiently high functioning to obtain a mental health practioner's degree in psychiatry, psychiatric nursing, psychology, social work, or mental health worker such as a Therapeutic Behavior Services (TBS) Coach or house parent. These individuals would have experienced the "therapist" when they went into therapy and the psychologist when they were tested, and the psychiatrist when they received medication. They would have experienced the affect of medication both in its benefit and its consequences through its side effects. They would have experienced various therapeutic modalities and have insight to the personal effectiveness as well as the function of the modalities on their family and in social settings. As they became adults they would have developed a comprehensive understanding of the System of Care in its benefits and its levels of dysfunction. They likely would have direct experience with community and client based support groups and peer-groups such as NAMI. They would have gone through Children and Youth Services into Adult Services and had received assistance from educational and social services outlets and would thereby have a wide network of professional and community based contacts. Having such people on the therapeutic team would clearly be advantageous.

In general there may be some or even many therapists with this background, but given the culture of the society and as a microcosm in the clinic certain therapists may not have revealed their lived experiences with their peers and supervisors. Given this likelihood, introducing and then seeking the inclusion of Dimensional Psychology/Therapy may provide permission to "Come out of the closet." Concurrent with this liberation, a program of recruitment would have to be initiated starting in the undergraduate programs, or maybe as early as high school. Identifying such young people experiencing and working through their mental illness would be a beginning of developing the support programs to mentor these students through high school, into and through college and graduate school. When these people become credentialed they would be hired as Dimensional Specialists. Initially their integration as a DS into the clinical settings would be in the role of being floaters, teamed with the general mental health practioners, to provide insight into the dimension of the specific mental illness. In time, with more recruits, such senior DS therapists would be able to carry their own specialty caseload or in some combination with being a floater.

Dimensional Psychology. What is it? The psychology of the dysfunctional subworlds hidden within the confines of what we call Reality. Psychology today views these subworlds single or two dimensionally, strictly through the features provided by the DSM. As a result the diagnosis is a cognitive surface projection of the subworld within which the client lives. For the therapist this would be something like being in a boat skimming on the surface of the ocean, only being aware of the surface's movement in the form of various types of waves and swell action. Of course the reality of the ocean is below the surface. The best therapists are akin to scuba divers who as they dive under the surface they discover the amazing aspect of the ocean's depth. However if we ever learn how to understand Whale Speak, we above surface air breathers would be enriched with

what the Whale's underwater lives and experiences could reveal. If the whales would allow collaboration, then this would be similar to what the Dimensional Specialists and the client would have to share and contribute as people who have lived the mostly invisible world of their diagnosis.

Bringing in the previous conversation on the hierarchy of therapy, on the inverse side, imagine working with the client so that they are introduced as a relevant member of the team with the lived insights from which the team would benefit should the client be treated as a guide into their lived dimension. With this encouragement and by allowing and promoting the client as an integral member of the team it would likely have the effect of reducing their feelings of being marginalized and analyzed resulting in their feeling increasingly appreciated and safe. What a boost to their self-esteem and empowerment. So therapeutic! Providing extensive in-service training for practicing therapists and coursework should they still be in school would be critical so that an atmosphere of congeniality and collaboration could be generated to support the extension of the client's role into that of a guide into their lived-dimension with the DS as their mentor. This transition will be challenging and yet wouldn't it enhance the healing aspect of therapy and communicate we practice what we preach? An interesting thought is that from the numbers of our clients, each with their own diagnosis and lived-dimension, some of them in time may grasp the dynamics of their disability and integrate the interventions so that they now can manage its influence. These clients would also be great candidates for recruitment into the therapeutic team as our peers once they completed their education and training.

The greatest challenge to the introduction of Dimensional Psychology/Therapy is that it may trigger in some therapists who haven't had the lived-experience the fear that they may be replaced. This would possibly create anxiety and a challenge to self-esteem resulting with the incipient feeling of being under threat causing a certain degree of reactive behavior that could block this possibility. It would only be human nature to feel this way to a certain degree. I can't answer this challenge with any counter argument. Those who felt this would require support into and through a transition. They would be challenged to approach this anxiety by being helped to acknowledge the feeling and start to work it through so that it could be managed. This directed therapy would likely strengthen their resolve to stay connected to their values that brought them into the field originally and experience the wonder of an expanded sense of self and others.

Should you wish to dialogue about Dimensional Psychology/Therapy I would be pleased to engage with you. My contact: Jonathan@outfar10.com

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