Workbook Chapter Two
Tame Your Inner Demons Through Self-Therapy

Self-Assessment Tools:

Self-Inventory: Self-Interventions for Finishing Any Unfinished Learning Experience From Your Family of Origin

Barry K. Weinhold, PhD

Directions: In the blank before each item indicate how much this issue affects your life and relationships: 1= Mostly not true; 2= Occasionally true; 3=Usually true; 4= Almost all the time.

Common Issue	**Unfinished learning Experience**	**Suggested Ways To Finish The Unfinished Learning Experience**
___1. Fear of being consumed	Child subjected to "helicopter parenting," parent hovers over the child	Role-play or have someone close to you role-play a parent who is doing this behavior and ask them to express any unexpressed feelings.
___2. Addiction to activities	Love and acceptance as conditional	Learn relaxation and meditation techniques.
___3. Victimization	Emotional, physical, and sexual abuse or shame-based discipline	Identify possible unfinished learning experiences and use TET process to heal them.
___4. Fear of influence from outside the family	Family secrets, an us vs. them attitude	Help uncover any family secrets and look at the impact they have had on them
___5. Secrets between family members	Shame-based parenting	Help identify possible use of shame to discipline you and the affects it has had on you.
___6. Unequal rights between adults and children	Authoritarian parenting style	Examine the source of your beliefs and values. Look at how authoritarian parenting might have affected you.
___7. Rejecting help from others even when needed	Neglect of needs, shame-based messages about expressing needs	Respect and take seriously all expressions of your needs. Examine the source of any resistance to doing this.
___8. Control and manipulation used to get needs met	Love and acceptance conditional	Learn to ask for unconditional support and acceptance from others when needed.
___9. Lack of respect for personal boundaries	No rights to privacy, children seen as extensions of parents	Learn how to say "no" as many ways as you can.

___10. Unwillingness to assume responsibility for actions	Self-management skills not taught effectively, personal boundaries not respected	All agreements need written down. Each person decides on his or her consequence for breaking an agreement, if necessary.

___11. Inability to handle time and money effectively	Little support for self-care	Invest in time and money management tools to improve these skills. If necessary, hire a financial advisor to teach you how to manage your finances.
___12. Intimidation or manipulation used to resolve conflicts	Not allowed to make own age-appropriate decisions	Create and enforce a no- power-plays contract. Encourage and support direct expression of feelings of shame.
___13. Suppression of feelings	Shame used to prevent independent ideas and actions	Learn how to use journaling to recover early memories of unfinished learning experiences.
___14. Belief in scarcity	Lack of support and positive feedback for independent efforts, no modeling of healthy expression of feelings	Give specific kinds and amounts of positive feedback every day.
___15. Lack of personal accountability	Efforts to become separate either overtly or covertly sabotaged, failures punished	Sign up for a risk-taking skill-building workshop to develop confidence.
___16. Rebellious and acting-out behavior, testing limits	Lacked effective limit setting, raised with permissive discipline practices	Set realistic limits for yourself on a daily basis.

___17. Indirect communication	Received messages that it was not safe to be a separate person, attempts to be separate punished	Take a public speaking or leadership development class. Learn to communicate your feelings & needs directly.
___18. Angry and/or violent behaviors	Possible unprocessed birth trauma or early abandonment experiences in which bonding needs were not met	Use breath work techniques with yourself.
___19. Addictive behaviors such as drinking, smoking,	No support for expressing feelings	Give and receive foot massages and other nurturing touch to close friends.

eating disorders, and drug use		
___20. Compulsive eating, smoking, drinking, or sex	Deprivation of nourishment and/or love, basic needs possibly neglected	Ask directly for help in meeting your needs.
___21. Feeling unconnected to others or isolated in the relationship	Early emotional or physical abandonment by those charged with caretaking	Identify unmet needs and ask each other directly for help in getting them met.
___22. Trouble trusting, suspicious of the motives of others	Birth trauma and lack of attention to needs at birth	Bathe in a quiet room filled with soft lights and soothing music.

___23. Parents using children to make themselves look good to others	Not enough mirroring of children's essence and positive responses from parents	Ask for reassurance in times of doubt or fear.
___24. Inability to define wants and needs, expecting others to just know how these needs should be met	Needs were anticipated and met prior to expression of children's needs for feeding, affection, changing diapers; parents possibly hovered and did not wait for signals for needs to emerge	Identify your own needs and affirm your right to get them met.
___25. Inability to shift from oneness to separateness without difficulty	Rigid atmosphere with everything either black or white, some traumatic experiences between ages of 1 and 2	Identify instances of trauma or repression in the family and to ask others for support to express your feelings about these experiences.
___26. Unwillingness to negotiate to get needs met	Subjected to win– lose methods of conflict resolution; negotiation interpreted as losing	Take a class in conflict resolution and learn win–win methods for conflict resolution
___27. Avoidance of intimacy through workaholism or other compulsive activity	Abusive or invasive relationship with an adult during childhood that made intimacy unsafe	Uncover instances of abuse or invasion and ask for support in expressing your feelings about these experiences.

___28. Resistance to participating in spiritual practices.	Spiritual trauma between ages of 4 and 12, religious abuse	Identify instances of spiritual trauma and ask for support in expressing

		your feelings about these experiences.
___29. Fear of abandonment	Removed from mother at birth and taken to nursery, abrupt or extended physical separation from mother during the first year of life reinforced by later experiences of traumatic separation	Learn how to effectively communicate with young children about leaving them for any reason, "I'm leaving now and I'll be back at ___"
___30. Breaking relationship agreements	Unpredictability used as a way to avoid abuse, invasion, or punishment from caregivers	Develop written agreements with each other, with agreed upon consequences for breaking them.
___31. Unwilling to accept past conflicts as the source of current conflicts.	Unprocessed rage from abusive and/or shame-based discipline and limit setting.	Identify instances of abusive and/or shame-based discipline and ask for support to express feelings about these experiences.

___Total Score
Scoring and Interpretation:

If your score was between:
31-50 Very few symptoms of unfinished learning experiences in your family of origin.
50-75 Presence of some symptoms of unfinished learning experiences in your family of origin.
75 + Presence of many symptoms of unfinished learning experiences in your family of origin. Pay particular attention to those items that had scores of 7 or more. Your response to these items indicates a strong presence of unfinished learning experiences. These situations need to be addressed to finish the unfinished learning experiences you had in your family of origin.

The Limitations of Cognitive Behavioral Therapy
Barry K. Weinhold, PhD

Here is a summary of the most common complaints about Cognitive Behavioral Therapy that are listed in the research literature:

1. Many studies investigating the use of CBT don't use well-constructed control groups. When they do, the effectiveness is still usually good, but not as impressive. For example, in a study on using CBT for panic the treatment group findings were impressive: 85 percent of patients were panic-free at posttreatment and improvements are maintained at follow-up.

   However, this study did have a good control group of waiting list subjects (not getting any therapy), which found that *26 percent of the control group* also improved to an acceptable degree. Therefore, while CBT was certainly effective, it wasn't exactly effective in 85 percent of the patients.

2. In addition, other studies have shown that CBT often fixes the worst symptoms, but not all of them. In a study on CBT for insomnia, many subjects who *improved did not become "good" sleepers*. It was certainly a worthwhile treatment, but clearly CBT alone in this context was not enough alone to fully cure a patient.
3. Finally, there are some studies that show that CBT may not be more effective than alternative treatments. For a condition like depression, alternatives like interpersonal therapy or clinical management plus antidepressants may be more effective.
4. CBT doesn't work for all psychiatric conditions: CBT is often prescribed for insomnia, but little research has been done on exactly how effective it is on different types of insomnia. In other words, CBT is typically studied for chronic insomnia, but not acute cases.

   In addition, insomnia can be caused by a wide variety of comorbidities, which are unlikely to respond equally well to CBT. The same can be said for any other condition treated by CBT. Different types of PTSD or depression may need more tailored intervention.

Other Limitations of Cognitive Behavioral Therapy
Barry K, Weinhold, PhD

Here are some other documented limitations of Cognitive Behavioral Therapy:

1. CBT doesn't necessarily work well for all types of problems, even for depression, where it is mostly used. When studied by The National Institute of Mental Health Study of Depression, two other forms of therapy – interpersonal therapy and clinical management (with antidepressants) performed better than CBT.
2. The long-term effectiveness of CBT is yet to be researched thoroughly. Since depression has a high probability of relapse, whether CBT will actually help the client in the long term has yet to be decided. Some studies show that CBT is more of a short-term approach.
3. Since CBT focuses on only current problems, behavior, and thoughts, many critics argue that it does not focus on the underlying mental conditions such as childhood trauma, which could be the root cause of most current symptoms.
4. While the CBT practice focuses entirely on the individual, it fails to consider the impact the client's family, friends, and community surroundings may have on them.
5. CBT focuses on the negative feelings, assumptions, and cognitive behaviors rather than the roots of depression. Some examples of these cognitive behavior include low self-esteem, self-blame, self-criticism, etc. While these may be the effects, they are not the cause of the client's current problems.
6. CBT puts terms such as negative and dysfunctional self-concepts on the same pedestal as irrational beliefs about oneself, which is wrong in many cases. If a client has undergone abuse in any form in their childhood, their negative self-concepts are not irrational at all. In such circumstances, CBT uses cognitive restructuring exercises try to help the client reframe their reality. Thus, again they are not looking for the underlying causes of the problem.

7. Some critics blame that behavioral therapy is a practice where unwanted traits and characteristics are seen as a dark spot in our ideal image, rather than a clue to our inner truths. Often, even personality traits such as shyness and introversion are being treated by CBT therapists as a disorder that needs to be fixed.

The Limitations of The Modern Medical Model of Mental Health Practice
Barry K. Weinhold, PhD

If you make use of the current modern medical model of mental health care, you are opening yourself to a number of serious, but perhaps unintended consequences. First, the medical model of treatment does not begin to operate until someone is sick.

This means that the first thing a good medical practitioner does is to diagnose the sickness. Then presumably, he or she knows better how to treat that illness. Most medical practitioners know nothing about how to prevent people from getting sick. Prevention is left to the epidemiologists.

This was painfully obvious when the COVID-19 pandemic hit. Traditional medical experts knew very little about how to prevent people from contracting the virus. First, they said don't wear masks, because they won't help prevent you from contracting the virus. Later, they changed their minds and urged a universal mandate on wearing masks, whenever you are in contact with others. Later in the game they added a required social distance to prevent you from contracting the virus.

Actually, there was very little good research on what worked best. Basically, most medical practitioners were out of their element and still are. I doubt that they have learned very much, that would help them give any better ideas to use when we have another pandemic.

Many alternative practitioners had lots more options to present, including building up your immunity to viruses through good nutritional supplements. However, due to the inner demons (pride and weak egos) of the traditional medical profession, they managed to totally block any suggestions of effective prevention remedies proven effective by alternative medical professionals from reaching the general public. They even demonized any remedies that came from any alternative medical professional.

When this medical model is applied to mental health treatment, it can produce serious unintended consequences. For example, when a licensed counselor or social worker sees a client for the first time, he or she has to come up with a diagnosis. That is how he or she gets paid. The diagnosis they use also often determines the number of sessions that they will be paid for. They have to give the client or patient a diagnostic label to tell the therapist and the client what is wrong with the client.

Most clients come to therapy believing there must be something wrong with them (shame). Upon receiving his diagnosis, what is wrong with them is confirmed. He now has a name for what is wrong with him. They now have a name for their shame.

This only further convinces them that there is something really wrong with them that only their therapist can fix. To me, all this does is make it harder for clients to shed the erroneous shame-based beliefs they have created about themselves, other people and the world around them.

This diagnosis also goes on their permanent health record, so from now on they are seen as a diagnosis not a person. There is almost no way to get any diagnosis

removed from your permanent health record. Many people with a diagnosis then adapt to being a "bi-polar" or a person with an illness. Even if their therapy is successful to some degree, the label is retained, because medical professionals always guard against a relapse.

There are national organizations to provide supportive services to clients or patients who have a diagnosed mental illness and have adapted to their chronic disease. One of the biggest organizations is NAMI, The National Alliance on Mental Illness.

There is a belief by the medically oriented mental health professionals that once you are diagnosed with a mental illness, you will never recover from it. The best you can hope for is to get support so the disease does not get worse with age and time. In my opinion, this is totally misguided support.

In addition, years later, even after you no longer are having any symptoms of this so-called disease, you are still considered sick with this incurable disease and it stays on your permanent health record. I know of a physician who asked his primary care physician for a prescription for some sleep medications. His doctor looked at the patient's permanent health record of this patient and saw that he had been diagnosed with major depression over 10 years earlier. Because the medication is not recommended for people with this diagnosis, he was denied the prescription. He ended up writing one for himself.

In addition, many people with no understanding of what a given diagnosis actually means, will view that health record and make erroneous decisions that could deny the client needed meds or other services. The message is: don't get a diagnosis and this realistically means don't enter the modern medically-oriented mental health care system.

How to Choose a Good Counselor or Therapist[1]

Noah Rubinstein, LMFT

If you do want to find a good counselor or therapist here are some things to consider: It's relatively easy to find a counselor, but perhaps it is more difficult to know if you've found a good one or someone who is right for you. It is important to interview several therapists to find the one that is a best fit for you.

There are a number of questions you can ask that will help you to choose a counselor. Here are some questions to consider, in no particular order (the words "therapist" and "counselor" are used interchangeably in this list of questions).

1. What does it feel like for you to sit with the therapist? Do you feel safe and comfortable? Is it easy to make small talk? Is the person down-to-earth and easy to relate to or does he or she feel cold and emotionally removed? Is the counselor overly cognitive or overly emotional and empathic? Does the therapist present himself or herself a "know-it-all" or a bit arrogant? Sure, for many of us, going to a therapist for the first time is a bit anxiety

provoking, and it's important to tease out our own "stuff" from that of the actual counselor. But, if a counselor doesn't feel like a good fit for you, that's okay; you are not required to continue working with any counselor. However, it's important to check to see if there's a part of you that is actually avoiding therapy that is expressed through a dislike or judgment of the therapist. If you find yourself reacting negatively to every counselor you see, then the issue could be yours and may warrant your sticking it out with a counselor in an effort to work through your resistance to beginning therapy.

2. What's the counselor's general philosophy and approach to helping? Does he/she approach human problems in a compassionate and optimistic way? Or does the counselor believe people are fatally flawed or genetically deficient?

3. Can the counselor clearly define what he or she will do to help you to solve whatever issue or concern that has brought you to therapy? Good counselors explain, in general, how they can help, are able to give you a basic information about their approach, and can often give you an indication of how you will know when your therapy is finished.

4. Does the counselor seek regular supervision? An important professional activity for any wise counselor is regular supervision with peers or consultants. Supervision serves a number of purposes, such as, but not limited to, reviewing cases, receiving advice, getting unstuck, discovering one's own blind spots, and noticing how one's own "stuff" may be getting in the way. Supervision provides a counselor with a necessary reality check, a degree of objectivity, and feedback. Even the best therapists benefit from the help of other peers.

5. Can your counselor accept feedback and admit mistakes? A good counselor is open to feedback and to learning about that something he or she might have said that hurt or offended you. Good therapists are open to feedback, are open to looking at themselves, can check their feelings, and can honestly and openly admit mistakes.

6. Does the counselor encourage dependence or independence? Good therapy doesn't solve your problems for you; it helps you to solve them on your own. Like the old proverb, therapy is best when it helps people to learn to fish for themselves rather than rely on another person to feed them.

7. Has your counselor done his or her own therapy work? It is okay to ask the therapist that question. Therapists who have been in their own therapy benefit from this as a learning experience and are probably better equipped to help you because of it. Most good healers are wounded healers—those who, in the process of healing their own wounds, have developed the know-how to help others to heal theirs.

8. Does the therapist have experience helping others with the particular issues for which you are seeking therapy? It is important to ask them why they might feel qualified to help you with your particular problem or symptoms. Be specific, and if the therapist does not give you a

feeling of confidence or even safety, then talk to another therapist or even ask for a referral to a therapist who might specialize in your particular problem or symptoms.

9. Does the counselor make guarantees or promises? It's important for a therapist to provide you with hope, but not any absolute guarantees. If you have the will to change and put in the necessary time and energy, any healing is possible. Healing can happen quickly in psychotherapy, but only after you have complete trust in your therapist. Overall, there are numerous factors that determine the success of the therapy process. Besides the competence of the therapist, the amount of time and energy you are willing to put into the process helps determine the outcome.

10. Does your counselor adhere to ethical principles in regard to issues such as boundaries, dual relationships, and confidentiality? There are established professional ethical standards that are designed to keep counselors from harming their clients. Most importantly, there is a guideline barring against dual relationships. When a therapist enters into a therapeutic relationship with a client, he or she should not establish any other relationship with that person, such as teacher, friend, employer, or family member, although there are some exceptions to this rule in villages or very rural communities. Specifically, bartering arrangements fall in this ethical standard and are to be avoided.

11. Is the counselor licensed? Licensure implies that a counselor has engaged in extensive postgraduate counseling experience which, depending on the state of licensure, may include up to 3,000 hours or more of required supervised experience. It also means the counselor has passed a licensing exam. There are many unlicensed therapists who have years of experience and do excellent work, but licensed counselors have (generally but not always) jumped through more hoops and have undergone more extensive supervision than unlicensed counselors. You should contact your state professional licensing board if you have any questions about the qualifications of the therapist you are interviewing. to verify the licensure of a provider.

12. Does the counselor have a graduate degree? Unfortunately, there are people who call themselves "counselors" or "therapists" because they have taken a weekend seminar or have learned a certain therapeutic approach. However, without a graduate degree in counseling, psychology, social work, marriage and family therapy, or another related field of study, such a person most likely lacks the education, training, and skills to provide safe psychotherapy and counseling.

13. Does the counselor have postgraduate training? Many new counselors fresh out of graduate school have had excellent cognitive learning but can lack enough actual counseling experience to be a good therapist and feel totally confident. Postgraduate training in a particular approach to psychotherapy can be the next step in a new counselor's career and is helpful in getting learning new skills.

14. Have any complaints been filed with the board? In every state that licenses counselors and therapists maintain a public record of any complaints that were made about his licensed professional. If so, what are the complaints, and have they been satisfactorily resolved?

Case Example:

I first met Cassie, age 38, (not her real name) about a year ago. She selected me through the Betterhelp client referral system after reading my profile. In her written profile, she indicated why she was seeking therapy. She wrote among other things, "I've been in therapy before, but I never felt like I'm able to get to the root of my issues. I would love to find a way to shake off the negative behaviors I learned at a young age, so that I can truly become the person I know I am capable of being."

In my first session with her, I started the session by telling her that I had read her reasons for seeking therapy and that I wanted her to know that I did not think there was anything wrong with her. And I wasn't going to be "Mr. Fix it." I then told her how I could help her reach her goal to "…truly become the person I know I am capable of being."

Through my work with her, mostly having her complete the self-assessment tools I sent to her (these are the same tools you have access to in the Workbook accompanying this book), and she began to recover her true self. She somehow knew the way she wanted to live her life was hidden under her inner demons. She learned to tame her inner demons. In one recent session, she reflected back on what I did that seemed to help her the most. She pointed to two things I told her.

The first one was my opening remarks to her about nothing being wrong with her. She said that her experience with traditional therapy had never allowed her to consider that she might not be so flawed. She told me that my words penetrated her inner shame-based beliefs in such a way that she began to believe in herself as someone who could learn how to shed her negative past. It freed her to look at herself in a new way.

The second intervention was similar. I told Cassie, "If you can name it, you can tame it." She said that phrase reverberated in her mind and that she often would repeat that phrase when she was working to tame her inner demons and change the long-term effects of her severe childhood abuse and neglect mostly perpetrated by her mother. Today, Cassie has recovered most of her true self and it is having a very positive on her relationship with her husband and her life in general. When you can name, it you can change it.

Footnote

1. Adapted from a post on May 14, 2007 by Noah Rubinstein, LMFT, LMHC, GoodTherapy.org Founder and CEO.