INTERNATIONAL JOURNAL OF
PSYCHOTHERAPY

Journal of the European Association of Psychotherapy

Volume 18 Number 2 July 2014

International Journal of
PSYCHOTHERAPY

The International Journal of Psychotherapy is a leading professional and academic publication, which aims to inform, to stimulate debate, and to assist the profession of psychotherapy to develop throughout Europe and internationally. It is properly peer-reviewed.

The Journal raises important issues in the field of European and international psychotherapy practice, professional development, and theory and research for psychotherapy practitioners, related professionals, academics & students.

The Journal is published by the European Association for Psychotherapy, 3 times per annum.

The focus of the Journal includes:

* Contributions from, and debates between, the different European methods and modalities in psychotherapy, and their respective traditions of theory, practice and research
* Contemporary issues and new developments for individual, group and psychotherapy in specialist fields and settings
* Matters related to the work of European professional psychotherapists in public, private and voluntary settings
* Broad-ranging theoretical perspectives providing informed discussion and debate on a wide range of subjects in this fast expanding field
* Professional, administrative, training and educational issues that arise from developments in the provision of psychotherapy and related services in European health care settings
* Contributing to the wider debate about the future of psychotherapy and reflecting the internal dialogue within European psychotherapy and its wider relations with the rest of the world
* Current research and practice developments - ensuring that new information is brought to the attention of professionals in an informed and clear way
* Interactions between the psychological and the physical, the philosophical and the political, the theoretical and the practical, the traditional and the developing status of the profession
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* Exploration and affirmation of the similarities, uniqueness and differences of psychotherapy in the different European regions and in different areas of the profession
* Reviews of new publications: highlighting and reviewing books & films of particular importance in this field
* Comment and discussion on all aspects and important issues related to the clinical practice and provision of services in this profession
* A dedication to publishing in European 'mother-tongue' languages, as well as in English

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This journal is therefore essential reading for informed psychological and psychotherapeutic academics, trainers, students and practitioners across these disciplines and geographic boundaries, who wish to develop a greater understanding of developments in psychotherapy in Europe.

Editorial

Courtenay Young

Editor, International Journal of Psychotherapy

Dear Readers and Subscribers to the IJP

The international world-view seems to be increasingly caught up with events like the forthcoming football World Cup in Brazil and the tennis championships at Wimbledon. Whilst we obviously wish our favourite national team all the success, and maybe also Andy Murray our best wishes to capture the Wimbledon title again, we must not lose sight of the very disturbing events that are happening in the Ukraine, in Syria, and the Sudan. What do these foretell?

George Friedman (2009) recently published a book called *The Next Hundred Years* in which he predicts: a second Cold War between Russia and the West; a "Polish-bloc" of alliances between middle-European states; the fragmentation of China in the 2020s; the expansion of Turkey in the 2030s; and a 3rd World War around 2050: a nice little catalogue of disasters, but from a very American perspective! Nostradamus (1503-1566) is also said to have predicted a massive conflict between good and evil in the early years of the 21st century. Edgar Case (1977-1945) predicted a 3rd World War between (possibly) Muslims and non-Muslims: *"Strifes will arise through the period. Watch for them near the Davis Strait in the attempts there for the keeping of the life line to land open. Watch for them in Libya and in Egypt, in Ankara and in Syria, through the straits about those areas above Australia, in the Indian Ocean and the Persian Gulf."* The ancient Tibetan prediction that there would be (I think it was) at least 40 wars in the 20th century, is very likely going to be outnumbered very soon by the number of wars in the 21st century and we are, as yet, only halfway through the second decade: *"When will we ever learn?"* as the 1960's protest song said. And so – whilst the future may be very grim - what is in store for you as you open this latest issue of the International Journal of Psychotherapy.

We start this issue with the second part of a seminal article from **Miles Groth**: *"The Return of the Therapeut: The Genuine Psychotherapist".* The first part of this article was published in the last issue, where he explored the present state of psychotherapy from the perspective that we may have 'lost' something of quality that the original 'Theraputes' probably had: a practice that was known as "the cure of souls" or "the therapy of the word". In this second part, he posits that (someone like) R.D. Laing had this quality and he tries to demonstrate this from his theory of practice and in his work.

The next contribution is a research article from a group from Columbia & Long Island University in New York, **Rebecca Kennedy, Helen Verdeli, Eleni Vousoura, Hilary Vidair, Marc J. Gameroff & Ruifan R. Zeng**: *"Incorporating Evidence-Based Practices into Psychotherapy Training in Clinical Psychology Ph.D. Programs in the United States",* which looked at empirically supported treatments (EST) and evidence based practice (EBP) and the current noticeable 'divide' between science (research) and clinical practice, and how these are incorporated (or not) into USA Clinical Psychology Ph.D. training programs. Essentially, much of the evidence-base practice research is ignored in the training of new psychologists: though this does vary according to certain demographics. There is also some (deserved, though somewhat played down => implicit) criticism of the current lemming-like rush towards ESTs and EPBs and how that might affect the training of new psychologists & psychotherapists.

In doing some investigation into this area, I came across an interview by **Tony Rousmaniere,** with **Scott Miller**, entitled *"Why Most Therapists Are Just Average (and How We Can Improve)",* which seemed to supply some interesting answers to the sort of questions that had

International Journal of Psychotherapy: 2014, Vol. 18, No. 2, pp. 3-4: ISSN 1356-9082
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been raised by these first two articles. Having contacts with the people who first published it, I asked them for their permission to re-print it here, which was kindly granted. Scott Miller is a well-known and published researcher in the field, who is interested in the 'Common Factors' in successful therapy. This is not a new model of therapy, but an in-depth look at what works for both the clients and for successful therapists. It de-bunks quite a lot of prevailing theories and comes up with some empirically based answers. Anyway, it gives some food for thought and we hope that you enjoy this.

Next we have an interesting piece of research from **Asta Prajapati**: *Pharmacology vs. Psychotherapy in the management of depression and anxiety disorders*. What is particularly interesting is that Asta Prajapati is **not** a psychotherapist, but **is** a pharmacologist. We really welcome such additions from parallel professions. As an aside, I recently sent out a link to a 'collection' of about 70 articles on Anxiety – admittedly from a particular (Behavioural Science) perspective - (that had been sent to me from Routledge [Taylor & Francis]) as their 'contribution' to Mental Health Awareness Week. This 'collection' is/was available for free internet access (explore.tandfonline.com/page/beh/mental-health-awareness-week-2014) until 31st July 2014, so you may be lucky to just catch it.

We next offer a contribution from a psychotherapist in China: **Theo Cope** writes on *Positive Psychotherapy: Priorities and Problems*. This was initially a (sort of) in-house gripe about intellectual property and the use of a 'title' without full recognition and proper ascribing, but – with a little editorial help – it got transformed into an interesting article in its own right.

This issue is finished off by an emotional and very interesting article by **Richard Erskine** on how to cope with someone-close-to-you's imminent death: *The Truth Shall Set You Free: Saying an Honest "Goodbye" Before a Loved-one's Death*. It is difficult to comment on what seems to be so obvious and natural, and also (at times) so difficult and emotional.

We then have a couple of book reviews and the usual 'professional / political 'page' (or two). These pretty much speak for themselves.

It is also a pleasure to report that the International Journal of Psychotherapy continues in its growth and development: we have established, much more clearly, our internal structure and allegiances, and we are also progressing satisfactorily towards our goal of being entered into the Thompson-Reuters Social Sciences Citation Index and thus obtaining an "impact factor". It really – **really** – helps if anyone who happens to be writing an article for another journal (with an impact factor) to 'cite' – as a reference – a previous article from this Journal. This helps to build our 'profile' and makes it much more likely that we will be accepted: not that there is any serious doubt, of course.

So, anyway, we hope that you enjoy these summer contributions, along with your observations of the World Cup, and (of course) Wimbledon or whatever your national or personal past-times or interests are.

Incidentally, to touch back into the opening theme: have you ever considered that (perhaps) nowadays football (in all its formats) is an emotional substitute – or a more acceptable form – for what would otherwise be World Wars, internecine aggression, or intercontinental and/or sectarian / religious rivalries?

Dr. W.B. Cannon eloquently suggested that athletics might be (in the New York Times, in April 1915 – some hope, given the date and the geo-politics of the time): J.A. Mangan suggests that often there is a parallel (especially from a Buddhist perspective) in his 2006 article, "Sport and War: Combative Societies and Combative Sports" (accessible here: www.sgiquarterly.org/feature2006Jly-2.html); and a post from "Buzzard" on Yahoo Answers (about 7 years ago) said that: *"Like the guy up there said, it could have a tribal element to it, two gangs sorting out who's better, etc ... shame that countries can't sort their differences out in that way - instead of invading Iraq, we could just have played them at football, and if they lost, Saddam would have had to stand down as team manager ... it would be a better world!"*

Anyway, let us hope so.

The Return of the Therapeut: Part 2: R.D. Laing and the Genuine Psychotherapist

Miles Groth

Submitted May 2013; peer-reviewed twice Nov. 2013; re-submitted and accepted for publication, Dec. 2013.

Abstract

An ancient religious group known as the *Therapeutes* may be understood as the implicit model for a practice that has come to be known as "the cure of souls" (Oskar Pfister) or "the therapy of the word" (Pedro Laín Entralgo) – in everyday parlance, psychotherapy. After Freud's remarkable vision of a situation and method of therapeutic encounter, psychoanalysis, there followed a period of medicalization of psychotherapy until the Scottish psychiatrist and psychoanalyst, R.D. Laing, again took up the original vocation of the therapeut in his existential-phenomenological approach to human suffering, which he characterized as "genuine psychotherapy." The first part of the discussion explored the history of this development. The second part examines the present state of psychotherapy in the context of that history and outlines Laing's renewal of the work of the therapeut. Laing's theory of practice as a psychotherapist is discussed in detail. This is the second part of the article: the first part was published in the previous issue: IJP, Vol. 18, No. 1., March 2014.

Keywords: psychotherapy, psychoanalysis, Therapeutes, existential psychology, phenomenology, R.D. Laing, Sigmund Freud, talking cure, therapy of the word, existential analysis

Die Rückkehr des Therapeuten: Der aufrichtige Psychotherapeut (Teil 2)
Zusammenfassung

Eine antike religiöse Gruppe, bekannt als Therapeutes, kann als unausgesprochenes Modell für eine Praxis dienen, welche als « Seelsorge « (Oskar Pfister) oder « die Therapie des Wortes» (Pedro Laín Entralgo) verstanden werden kann. In unserer Alltagssprache ist dies die Psychotherapie. Nach Freuds bemerkenswerte Vision einer Situation und Methode der therapeutischen Begegnung , die Psychoanalyse; folgte eine Periode der Medikalisierung der Psychotherapie bis der schottischen Psychiater und Psychoanalytiker RD Laing, sich wieder auf die ursprüngliche Berufung des Therapeutes besann. Seinen existentiellen - phänomenologischen Ansatz, für die Behandlung des menschlichen Leidens, bezeichnete er als « echte Psychotherapie.“ Der erste Teil der Diskussion erforschte die Geschichte dieser Entwicklung. Der zweite Teil untersucht nun den aktuellen Stand der Psychotherapie, im Kontext dieser Geschichte und skizziert die Erneuerung der therapeutischen Arbeit von

International Journal of Psychotherapy: 2014, Vol. 18, No. 2, pp. 5-20: ISSN 1356-9082
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Laing . Laings Theorie der Praxis des Psychotherapeuten wird im Detail diskutiert. Dies ist der zweite Teil des Artikels : Der erste Teil wurde in der letzten Ausgabe veröffentlicht : IJP, Vol. 18 , Nr. 1, März 2014 .

Schlüsselwörter: Psychotherapie, Psychoanalyse, Therapeutes, Existentiale Psychologie, Phänomenologie, R.D. Laing, Sigmund Freud, Sprechkur, Therapie des Wortes, Existenzanalyse

Le Retour du Thérapeute (Partie 2): Le Vrai Psychothérapeute
Résumé

Un ancien groupe religieux connu en tant que *Thérapeutes* peut être compris comme le modèle implicite pour une pratique qui est venue à être appelée « le soin des âmes » (Oska Pfister) ou « la thérapie de la parole » (Pedro Lain Entralgo) – autrement dit, de la psychothérapie. Après la vision remarquable de Freud sur une situation et une méthode de rencontre thérapeutique, la psychanalyse, une période de médicalisation de la psychothérapie a suivi jusqu'à ce que certaines personnes, tel que le psychiatre et psychanalyste écossais R.D. Laing, ont repris la vocation originale du thérapeute dans son approche existentielle-phénoménologique vis-à-vis de la souffrance humaine, qu'il a caractérisé comme la « psychothérapie vraie ». La première partie de la discussion a exploré l'historique de ce développement. La seconde partie examine l'état actuel de la psychothérapie dans le contexte de cet historique, et trace le rôle de Laing dans le renouveau du travail du thérapeute. La théorie de la pratique psychothérapeutique de Laing y est discutée en détail. Ceci est la seconde partie de l'article : la première partie a été publiée dans l'édition précédente : IJP, Vol. 18, No. 1, Mars 2014.

Mots clés : psychothérapie, psychanalyse, Thérapeutes, psychologie existentielle, phénoménologie, R.D. Laing, Sigmund Freud, cure par les mots, thérapie de la parole, analyse existentielle

Возвращение терапевта: Истинный психотерапевт (часть 2)
Резюме

Имплицитной моделью практики, которая стала известной как практика «исцеления душ» (Оскар Пфистер) или «терапия словом» (Педро Лэйн Энтральдо), или, говоря обыденным языком, «психотерапия», может считаться древнее религиозное учение *Therapeutes*. После знаменитого концептуального видения ситуации Фрейдом и его метода терапевтической встречи – психоанализа, последовал период медикализации психотерапии. Это происходило до тех пор, пока шотландский психиатр и психоаналитик Рональд Лэнг не вернулся к первоначальному пониманию истинного назначения терапевта (*therapeut).* Лэнг охарактеризовал свой экзистенциально-феноменологический подход к работе с человеческим страданием как «истинную психотерапию». В первой части данной статьи описывалась история вопроса. Во второй - нынешнее состояние психотерапии в историческом контексте. В ней также кратко излагаются идеи Лэнга по восстановлению понимания сущности работы психотерапевта и детально обсуждается его теория о практике психотерапии. Первая часть была опубликована в предыдущем номере журнала: IJP, Vol. 18, No. 1., March 2014.

Ключевые слова: психотерапия, психоанализ, Therapeutes, экзистенциальная психология, феноменология, Р. Лэнг, З. Фрейд, исцеляющая беседа, терапия словом, экзистенциальный анализ.

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In the first part of this discussion, I traced the history of what I term the *therapeut* (a practitioner of what Pedro Laín Entralgo termed "the therapy of the word") to an ancient Judaeo-Christian sect, the Therapeutes. I described how their practice of "the cure of souls" (as Oskar Pfister described psychoanalysis) differed from the *ars muta* (silent art) of the physician. Finally, I pointed to its re-emergence (perhaps predictably) at the end of the 19th century in the method of psychoanalysis developed by Sigmund Freud and its renewal in the 1960s in the work of the Scottish psychiatrist R.D. Laing. In this part, I will look closely at Laing's practice and the prospect of its further development as a form of existential-phenomenological analysis inspired by him. This will involve trying to articulate just what is *therapeutic* in the "therapy of the word."

To try to determine the source of what more precisely is therapeutic in the "therapy of the word," I will use the example of a post-psychoanalytic psychotherapist in the tradition of the Therapeutes, R.D. Laing (1927-1989).[1] I will suggest that there was something in Laing's stance that hearkens back via Freud to the Therapuetes and points forward to a new generation of existential-phenomenological therapeuts. There are several other potential candidates, such as Harry Stack Sullivan, Jacques Lacan and M. Masud R. Khan, who were all known for their exceptional skill as therapeuts. I choose Laing because of his remarkable personality, but also because there are available samples of him conducting psychotherapy.[2]

My memory of Laing, in person, is dominated by an image of the way that he responded to the individuals with whom he spoke during a question and answer session following his formal presentation at a fairly large venue (Groth, 2001). When asked a question and before answering it, he got up from his chair and placed himself directly in front of the person to whom he was responding. This meant he crossed the stage to face the panellist (his back was now to the audience). Laing also went down into the auditorium in order to meet his various interlocutors seated there. I had never seen anyone behave like this at a conference and have not seen it since that evening. I could say "my evening" because, even though I did not raise a question, I had the feeling that he was there for me alone. I sensed this was the impression that he seemed also to have elicited in many others present.

Laing did not look into the eyes of the person he was listening to or addressing. He looked down, his eyes narrowed as though he were peering into a microscope. I had the thought that he seemed to be praying in front of them. So powerful was his presence, it seems to me now, that if he had been gazing directly into the eyes of the person with whom he was listening or speaking, he would have invaded their personal space. On the other hand, his physical

1 I was fortunate enough to observe Laing in person once, albeit (sadly) at a distance. Unlike most psychotherapists, he was willing to be seen at work. The records of Laing engaged in psychotherapy are exceptionally rich. These include episodes in the documentary of his life, Did You Used to Be R.D. Laing? Santa Monica: Direct Cinema, 1989. For other records of Laing's practice, see Existential Psychotherapy, Phoenix: Milton H. Erickson Foundation, 1985; Eros, Love, and Lies, Cooper Station: Mystic Fire Video, 1990; and Approaches, Kino Video, 1974. In Existential Therapy Laing sits across from a homeless woman. See C.F. Clark, "What Was Therapeutic about That?," in Journal of Transpersonal Psychotherapy 36 (2), 2004, pp. 150-179, which contains a transcript of the session. Carlos Amantea, The Lourdes of Arizona, San Diego: Mho & Mho Works, 1989, includes an interview with Laing about his session with the woman.

2 In one place, regarding the origin of the therapeut, Laing is reported to have said: "Healers are either born to be healers, or they are initiated by other healers." Bob Mullan (Ed.), R.D. Laing. Creative Destroyer, London: Cassell, 1997, p. 342, as reported by Andrew Feldmar in conversation with Laing in 1974. Laing frequently referred to himself as a "social phenomenologist" influenced most of all by the existential and phenomenological traditions. He wanted to be remembered as a European intellectual. See Bob Mullan, Mad to Be Normal. Conversations with R.D. Laing, London: Free Association Books, 1996. R.D. Laing. Creative Destroyer includes reminiscences and reflections by sixty colleagues, friends, scholars and patients.

closeness seemed to do what the gaze accomplishes from a distance. Laing was able to be intimate, without encroaching on the Other, and to be close without dominating him or her. I also had the impression that he was guarding, even protecting, each individual to whom he was listening and responding.

I am unable to describe Laing's full presence. I can only say that he was wholly *there* with each individual, even though there were many bodies and auditors nearby. He focused and concentrated this intimacy, first on one person, then on another, without giving the impression that he was leaving behind the person he had just spoken with. I take this to be exemplary of how Laing interacted with people whom he took seriously.[3]

He was simply acting as he would any time that he was in the presence of another human being who mattered to him. And somehow, each in turn, *everyone seemed to matter to him*. Laing appeared to be not at all interested in the large group of people who were leaning on his every word. I would go so far as saying that he was unaware of the crowd. It seemed to me that he was "at home" only one-to-one with other human beings. In short, even with an audience of several hundred people, Laing appeared to be "in private" with each person there. It is what he called therapeutic "co-presence" when he was engaged in individual psychotherapy (Shandel & Tougas, 1989).

As I watched Laing then and, much later, after I had watched him on video-tape, I tried to recollect what he had written about his therapeutic stance or style. In what follows, I will now attempt to characterize who he was and what he did that makes him – for me – the exemplar of the therapeut, or the practitioner of the "therapy of the word." I see him as representing both the stance of the Therapeutes of the past and the existential-phenomenological practice of psychotherapy in the future.

II

In his autobiography, which covers the period of his life leading up to the publication of his first book, *The Divided Self*, Laing (1985) begins by recounting his training as a psychiatrist and his first experiences with institutionalized, severely disturbed "patients." He then writes in general terms about how any two people relate to one another, but the background of his reflections remains his work with "back ward" patients. He writes about the "presence" of the other:

> This presence, so immediate to our sensibility, of the other eludes being pinned down entirely objectively. A few moments ago there was just a body making a few movements. *Now, someone is there.* The moment we snap into this sense of the immediate presence of the other, movements express intentions, and we are back in the realm of human conduct, however vestigial. Our sense of the presence of the other endows his or her movements with meaning. . . . This movement of recognition of the other may coincide with the first time we feel 'looked at' by the other 'coming around.' We feel the other feels us [emphasis added] (p. 119).

I am sure that the individuals whom I watched Laing talking with that night in New York had that experience of being "looked at" in which they felt Laing "feeling" them. I have seen this in taped sessions of Laing with other individuals and have read about it in the reflections of friends and colleagues, including some who were in supervision with him as young practitioners. The mutuality of feeling and the feeling of mutuality were hallmarks of Laing's therapeutic style and, evidently, were the foundation of his success with even initially

3 For examples of this in the accounts of Laing's friends, see Mullan (1997).

"inaccessible" hospitalized patients.

Laing concludes his autobiography with a reference to *The Divided Self*. It is clear from what he says, that, even as a young psychiatrist, he had already found a way of working with patients that exempted them from both their self-enclosing clinical diagnosis and his potentially off-putting status as their psychiatrist. The therapeut recognizes that there are hierarchies everywhere in life, but refuses to acknowledge them in the interest of establishing and maintaining parity in the psychotherapeutic setting.

In the section "The Relationship to the Patient as Person or as Thing" of *The Divided Self*, Laing explicitly identifies his orientation as a therapist as existential-phenomenological. Although his topic is psychotic patients (the group who were initially his specialty), what Laing says here applied to any individual who was in psychotherapy with him. Laing writes that the therapeutic relationship has the features of Buber's I-Thou relation (Laing, 1960, p. 87) and that his focus is on "the patient's way of being-with-me" (Ibid, p. 24). He adds that, as a psychotherapist,

> [o]ne has to be able to orient oneself as a person in the other's scheme of things, rather than only seeing the other as an object in one's own world, i.e. within the total system of one's own references. The *genuine psychotherapist* must be able to effect this reorientation without prejudging who is right and who is wrong with respect to what is real [emphasis added] (Ibid, p. 25).

A second principle of Laing's therapeutic work "*is the crucial one in psychotherapy as contrasted with other forms of treatment. This is that each and every man is at the same time separate from his fellows and related to them*" (Ibid, p. 25). It is especially crucial in the psychotherapeutic endeavour for the therapeut to bear in mind that he and his client are, existentially, in the same boat. That is to say, they are *alone together* in their undertaking. What goes on in life also goes on in psychotherapy, although, in the latter, the isolation of the participants from each other is highlighted and becomes, along with much else, a theme for investigation and elucidation.

Using the language of psychoanalysis, Laing discusses the use of interpretation with his patients.[4] He draws on Dilthey's (1907) notion that the interpretation of a text implies a *relationship* between the author of a text and the reader, noting that the psychotherapeutic relationship is comparable. This is especially important when working with individuals whose sense of reality differs dramatically from that of most people.

> Like the expositor [of a text], the therapist must have the plasticity to transpose himself into another strange and even alien world. In this act, he draws on his own psychotic possibilities, without foregoing his sanity. Only thus can he arrive at an understanding of the patient's *existential position* [emphasis added] (Ibid, p. 34).

To repeat: What Laing says about transposing oneself into the world of a psychotic individual holds for working with anyone in psychotherapy. What is there to be understood is the "existential position" of the other. Laing comments on the nature of such "understanding" of the other:

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4 Considering Freud's understanding of the place of interpretation in psychoanalysis, on this and related matters it is always important to bear in Laing's relation to psychoanalysis. See Michael Guy Thompson, "Deception, Mystification, Trauma: Laing and Freud," in Psychoanalytic Review 83, 1996, pp. 827-847; "The Heart of the Matter: R.D. Laing's Enigmatic Relationship with Psychoanalysis," in Psychoanalytic Review 87, 2000, pp. 483-509; and "Existential Psychoanalysis: A Laingian Perspective," in Paul R. Marcus and Alan Rosenberg (Eds.), Psychoanalytic Perspectives on the Human Condition, New York: New York University Press, 1998, pp. 332-361.

> For understanding one might say love. But no word has been more prostituted. What is necessary, though not enough, is a capacity to know how the patient is experiencing himself and the world, including oneself. If one cannot understand him, one is hardly in a position to begin to 'love' him in any effective way (Ibid, p. 35).

This is a powerful challenge to the antiseptic stance of the psychiatrist, who on Laing's account would appear to be precluded from understanding his patient. Instead, the psychiatrist is left with the task of explaining behavior and little else.[5] But behavior is merely what it is unless the experience that motivates it is understood. Such an understanding is Laing's goal. He couches his aim in terms of devotion and "love" of the Other.

In *The Self and Others* (1961), his second book, Laing makes a number of observations about "confirmation or disconfirmation in psychotherapy" that reveal a great deal about his therapeutic style.[6] Considering the validation of the existence of the Other, he cites his experience with a woman who, after ten minutes of immobile muteness, entreated him not to move away from her. Laing admits, in hindsight, that he had lost interest in her during the "catatonic" (my interpretation) interval and his *"mind began to drift away on preoccupations of my own."* He had not changed his position in space relative to her, yet she had experienced a distancing and Laing realized he must confirm the woman's perceived removal of her existence from his presence and acknowledge *"the fact that she experienced me as away."* Rejecting some possible theoretically correct standard psychoanalytic interpretations, he said: *"The most important thing for me to do at that moment was to confirm that she had correctly registered my actual withdrawal of my presence."* He concluded that *"the only thing, therefore, I could say to my patient was, 'I am sorry'"* (Ibid, p. 88).[7]

In "The Psychotherapeutic Experience (From the Point of View of the Psychotherapist)" (Laing, 1967, pp. 46-56), an important text that dates from 1964,[8] Laing characterized psychotherapy as an enterprise that *"consists in the paring away of all that stands between us, the props, masks, roles, lies, defences, anxieties, projections and introjections, in short, all the carryovers from the past, transference and countertransference, that we use by habit or collusion, wittingly or unwittingly, as our currency of relationships"* (Ibid, p. 46).

Instead of being preoccupied with the concerns of classical psychoanalysis about the past, the psychotherapist must focus *"on what has never happened before, on what is new"* (Ibid, p. 47). In this text, Laing was very likely talking about himself when commenting on new developments in psychotherapy that heralded such a change of outlook:

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5 This is precisely what has come to pass in the world of the Diagnostic and Statistical Manual of Psychological Disorders, where there is scant reference to experience and the diagnostic features are effectively limited to observable behavior. This is also the stance of much psychotherapy and counseling, from psychodynamic to cognitive-behavioral modalities as they are currently practiced.

6 This is Laing's second book, which was meant to be the second part of The Divided Self. It reappeared eight years later "extensively revised," as Self and Others, New York: Pantheon, 1969. The revised text titled without the initial definite article is in many ways a very different book than its predecessor. During the1960s, Laing changed in important ways.

7 On existential nearness and distance, see the protocols of Martin Heidegger's meetings with residents in psychiatry, in Martin Heidegger (Medard Boss [ed.]), Zollikon Seminars. Protocols--Seminars--Letters, Evanston: Indiana University Press, 2001. First published in 1987, the volume covers a decade of seminars (1959-1969) held at Boss's home. Heidegger influenced Laing more than other philosopher, including Jean-Paul Sartre, about whom he co-authored with David Cooper the volume Reason and Madness, London: Tavistock Publications, 1971.

8 The text is "a revised version of a speech to the Sixth International Congress of Psychotherapy, London, 1964, entitled 'Practice and Theory: The Present Situation'" (Laing, 1967, p. 5).

> *The therapist may allow himself to act spontaneously and unpredictably.* He may set out actively to disrupt old patterns of experience and behaviour. He may actively reinforce new ones. One hears now of therapists giving orders, laughing, shouting, crying, even getting up from that sacred chair [emphasis added] (Ibid, p. 47).

Strictly forbidden by orthodox psychoanalytic technique, Laing allowed himself such comportment with his patients, as we see in excerpts from sessions with a woman in *Did You Used to Be R.D. Laing?* (Shandel & Tougas, 1989), in which he sits on the floor, cross-legged, near her.

Evidently, Laing often surprised his patients. In interviews, however, he was clear that he never took advantage of the Other's vulnerability. Having a powerful influence on the person – what I would term precisely a therapeutic effect on the Other – did not provide Laing with license for trying to have his own needs met.[9]

One of Laing's most memorable and oft-quoted statements on psychotherapy appears in this text. It succinctly characterizes the existential-phenomenological stance he epitomizes: *"Psychotherapy must remain an obstinate attempt of two people to recover the wholeness of being human through the relationship between them".* (Ibid, p. 53)

While Laing claimed there are a few "*general principles . . . for the man who has both quite exceptional authority and the capacity to improvise*" (Ibid, p. 47) in the therapeutic setting, he did not articulate anything that could be construed as a technique. One thing was very clear to him, however: *"Any technique concerned with the other without the self, with behaviour to the exclusion of experience, with the relationship to the neglect of the persons in relation, with the individuals to the exclusion of their relationship, and most of all, with an object-to-be-changed rather than a person-to-be-accepted, simply perpetuates the disease it purports to cure*" (Ibid, p. 53). Beginning from the assumption that both therapist and client are in the same existential "fix," each alienated from his self, but to varying degrees, Laing observes:

> The psychotherapeutic relationship is therefore a re-search. A search, constantly reasserted and reconstituted, for what we have all lost and whose loss some can perhaps endure a little more easily than others, as some people can stand lack of oxygen better than others, and *this re-search is validated by the shared experience of experience regained in and through the therapeutic relationship in the here and now* (Ibid, pp. 55-56).

But what must happen in psychotherapy to allow this to happen? What brings about the transforming effect that allows the Other to rediscover what he or she has lost? Once again, Laing is not specific. There were the standard regularities of a meeting place and time and the exchange of money, but what is new here is the openness and directness that characterized Laing's therapeutic style.

Yet surely this refers to experiences that are the effect of the work of only a few charismatic healers. Laing raises and answers the possible objection himself: *"Does this mean that psychotherapy must be a pseudo-esoteric cult? No!"* (Ibid, p. 56) Yet, it may remind us of an ancient sect.

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9 On the one hand, like any psychotherapist, Laing charged a fee for his time, and that is surely the only expected compensation for doing this kind of work in a culture whose economy is based on the payment of money for goods and services rather than an exchange of them. On the other hand, Laing is known to have formed personal relationships with former "patients." Should this cause us to discredit his work with those individuals when he was their psychotherapist? Not at all.

Towards the end of his life, on occasion Laing spoke about psychotherapy in his public presentations. In 1985, at the Third Conference on "The Evolution of Psychotherapy" (the so-called "Woodstock of Psychotherapy"), he said:

> In a sense, psychotherapy is applied theology, applied philosophy, applied science. Our psychotherapeutic tactics and strategies are predicated upon, and are permeated by, who and what we take ourselves to be, how and what we wish and do not wish, want and dread, hope and despair, to be, in and through our experience and conduct. All that is the theory and praxis of *existential phenomenology* in psychotherapy [emphasis added] (Laing, 1987, p. 205).

Laing's reference to existential phenomenology once again as the basis of his practice of psychotherapy is very significant. It reminds us that this philosophical perspective was at the core of his practice.[10]

III

Laing's most extensive comments on "doing" psychotherapy appear in his transcribed conversations with Bob Mullan (1996), an erstwhile psychiatric social worker who had been preparing to write Laing's biography not long before Laing's death.[11] They are worth excerpting extensively since they are his most extended discussion of psychotherapy as he practiced it.

Contrasting his therapeutic stance with the psychoanalytic method in which he had trained at the Tavistock Clinic in London, he offered the following modest appraisal:

> My "patients" would want in a sense to get from me my view of them, well, they *would* get it, and then they could go away and make the best or the worst of it. I mean, "I'm not saying that this is going to do you any good, but if you are coming to see me and if what you want to get from me is how I see your life and the situation you're in and you think that will help you well I don't mind giving you that. But I am not promising you that this is going to be therapeutic. I don't know whether you can take this, one thing - just one thing, don't kill yourself on my doorstep . . ." (Mullan, 1996, p. 317).

Note especially the scare quotes around the word 'patients'. By this time (if he ever did) Laing did not think in terms of the hierarchy of physician-psychiatrist and patient, but rather in terms of what I refer to as "the Other." He may appear to have been glib, even harsh here, but he quickly adds:

I might say that to somebody, I might not say that to someone else. With someone else I might be tender and gentle. . . . You can't then codify that and say this is what you say. That would be my response to one person, but there would be a completely different response to another.

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10 On Laing's relation to existential phenomenological philosophy and psychoanalysis, see M. Guy Thompson, "The Existential Dimension to Termination," in Psychoanalysis and Contemporary Thought 17, 1994, pp. 355-386, and "The Fidelity to Experience in R.D. Laing's Treatment Philosophy," in Contemporary Psychoanalysis 33, 1997, pp. 595-614; Steven Gans, "Awakening to Love: R.D. Laing's Phenomenological Therapy," in Psychoanalytic Review 87, 2000, pp. 527-547; and Kirk Schneider, "R.D. Laing's Existential-Humanistic Practice: What Was He Actually Doing?" in Psychoanalytic Review 87, 2000, pp. 591-600.

11 Although he had several book projects in mind during this period of his life, this was the one Laing was at work on in the last months of his life. He hints at such an understanding of the extensive interviews he was giving Mullan (p. 251). The conversations took place in 1988 and 1989, the year Laing died. We have Mullan to thank for a rich oeuvre on Laing. Best known as a documentary film maker, Mullan is currently involved in a project that will present a fictional account of Laing's work and personality: www.gizmofilms.eu.

So I am responding. What I am offering is my contribution and my *availability* to them if they feel that a touch of *me* in their life would be useful to them. They can have it for a fee because I have to live too and they've probably got a lot more money than I have. . . .Well, I had a bit of a severe tone just now, but you know what I mean [emphasis added] (Ibid, p. 318).

On the sense of what was therapeutic in what he did, Laing notes:

> … the word therapy has got an etymological meaning that I favoured . . . the etymology means attentiveness, so the name of the game is cultivating tactful attention to each other, *attentiveness*. So I'm offering my attention and my response in my judgment of what is appropriate, of how to respond to you. I'll be attentive to you [emphasis added] (Ibid, p. 320).

He expands on the theme of attentiveness:

> I think the bottom line is that they've had my company . . . and *attention*. They've had my company and attention, and my *engagement* [Laing uses the French word] on their behalf. . . . As a matter of honor on my part they've had my attention and I've put myself at their service, and of their life and addressed myself as best I could to what's troubling them. The way that could turn out could take many different varieties of the range of my presence and attention and my training, and my hopefully refined, trained, cultivated intuition, spontaneity and sensibility (Ibid, pp. 328-329).

It becomes clear that what psychoanalysts term the "real relationship" (Greenson, 1967) is central and more important than the therapeutic alliance or transference: *"I developed the practice that the meeting ought to be conducted within the form of civilized courtesy. Courtesy"* (Ibid, pp. 320-321). Again referring to the initial encounter, Laing, somewhat surprisingly, tells us:

By this time I was in no way committed to the idea that [a person] had come to see me for *psychotherapy*. They had come to see me for a consultation as to what I could contribute to their life positively, which might not be a recommendation to get into therapy, it might be anything, absolutely anything (Ibid, pp. 321-322).

I take Laing's qualification about what he might be said to be doing as an implicit critique of psychotherapy as it was (and still is) being practiced. He discusses this in more detail a few minutes later in his conversation with Mullan.

Laing is careful to point out that he was not physically intimate with the individuals he worked with. He never "cuddled" with them (Ibid, p. 322). On the other hand, he sometimes offered himself in ways that to contemporary practitioners must seem extraordinary. Early in his career, for example, he brought home one of his severely disturbed young male inpatients to live for a time with his wife and children (p. 316).[12]

Laing then attempted a summary of the nature of his work as a psychotherapist:

> Since the days of the padded cells in the '50s, what I've been doing is in one sense so different from the understanding of psychotherapy from practically all psychotherapists. Is [what I do] psychotherapy, what is psychotherapy? . . . [P] sychotherapy is extremely hard work because it entails giving one's attention and the availability of one's presence. Listening in the first place is very hard work. You *can* get used to listening and practice listening and then it becomes less hard work very often as time goes on. But if you ask me what I have done or given to

12 The young man, Peter, is discussed in his first book (Laing, 1960, pp. 129-144).

> people, a lot of people who have come to see me have said that *the main thing they have gotten from me is that I listen to them. They have actually found someone who actually heard what they are saying and listened. That in itself without saying anything can be of critical importance.* We are social beings, somehow or other. For many people in their walks of life, there's no one listening to them, no one hears them, no one sees them, they are made up by everyone, they feel quite rightly they are ghosts. They might as well be dead, as far as their nearest and dearest are concerned. They are other people's phantasy. That can sometimes get someone down, and so if they come to see someone who actually sees and hears them and actually recognizes their reality, their *existence*, that in itself is liberating. In fact, that's got to be there in terms of what I do or nothing else is there, otherwise they could just as well go along and consult a computer who would do the job a lot better than most therapists [last emphasis added] (Ibid, pp. 330-331).

What, then, is the essential feature of the therapeut as we see him in Laing? This exchange between Mullan and Laing contains a not-so-surprising allusion:

> [Mullan] [Ivan] Illich says the best psychiatrists are 'latter day priests' of some sort or other . . .[13]
>
> [Laing] Eric Graham Howe would pick that up and say, Well, yes, as a priest after the order of Melchizedek, a priest without portfolio or any pretence to any credentials of a priest, and certainly not wearing a dog collar or anything. In that sense, yes, and only in that sense.
>
> [Mullan] And you see yourself in that sense?
>
> [Laing] In that sense.
>
> [Mullan] Someone struggling with problems of living?
>
> [Laing] Yes. As one human being to another. (Ibid, pp. 334-335).

A "priest without a portfolio" may suggest one of the Therapeutes from a time before there were priests in the Christian tradition.

In the end, Laing's existential-phenomenological stance prevails: two individuals working in the psychotherapeutic setting are two people together "struggling with the problems of living," working "as one human being to another" in relationship.

As for there being a kind of practice that could bear his name, Laing makes a statement that sets him apart from the psychoanalysts and all those who would consider themselves representing a school or modality of psychotherapy. Again, a brief exchange between Mullan and Laing:

> [Mullan:] What would make it Laingian therapy in the end?
>
> [Laing:] *Laing* (Ibid, p. 327).[14]

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13 I have not been able to locate the reference to Illich.

14 An illuminating early portrait of Laing, from 1972, when his popularity in the United States was at its height, is Peter Mezan, "After Freud and Jung, Now Comes R.D. Laing. Pop-Shrink, Rebel, Yogi, Philosopher-King? Latest Incarnation of Aesculapius, Maybe?" in Esquire, January 1972, pp. 92-97, 160-178. In addition to Bob Mullan's books already cited and his R.D. Laing. A Personal View, London: Duckworth, 1999, there are also the following biographies: Richard I. Evans, R.D. Laing. The Man and His Ideas, New York: Dutton, 1976; Richard I. Evans, Dialogue with R.D. Laing, New York: Praeger, 1981; Adrian C. Laing, R.D. Laing: A Biography, London: Owen, 1994 (written by Laing's son); John Clay, R.D. Laing. A Divided Self, London: Hodder and Stoughton, 1996; Daniel Burston, The Wing of Madness: The Life and Work of R.D. Laing, Cambridge: Harvard University Press, 1998; and Allan Beveridge, Portrait of the Psychiatrist as a Young Man: The Early Writing and Work of R.D. Laing, 1927-1960, Oxford: Oxford University Press, 2011 (which covers the same period as Laing's autobiography). See also M. Howarth-Williams (1977), R.D. Laing. His Work and Its Relevance for Sociology, London: Routledge & Kegan Paul.

IV

Laing's presence among psychotherapists today is once again becoming stronger, especially among those with an existential-phenomenological perspective. Unhappily, we hear little now of or from his successors in residential treatment centres in the United Kingdom, or from those whose practice has been influenced by his example of what I have here termed the therapeut. Laing's influence now flows mainly through his books and the work of scholars and the occasional practitioner, whose contributions and stance may only indirectly reflect Laing's re-envisioning of psychotherapy. On the other hand, there are signs of Laing *revividus* – of Laing the therapeut *par excellance*.[15]

I have singled out R.D. Laing as perhaps the most important representative of the new Therapeutes since Freud and a few of his bold followers. With his example in mind, it remains to summarize what I take to be the uniqueness of the practitioner of "the therapy of the word" – the therapeut. By now it should be obvious that I see the Therapeutes as forerunners of the existential-phenomenological therapeut, much as I see Freud, Laing and a few other psychotherapists I have known as bearers of that tradition, which had been so long in eclipse.

What are the features of the therapeut, "the good healer of minds," the practitioner of "the therapy of the word" and "the cure of souls"?

The human relationship between the therapeut and the Other is central to what happens between them that will be therapeutic for the Other (as well as for the therapeut). The "real relationship" takes priority over the therapeutic alliance and transference. In its classic psychoanalytic form, the therapeutic relationship occurs at three levels: the therapeutic alliance, the transference, and the real relationship (Greenson, 1967). From the point of view of the analysand, (a) the therapeutic alliance allows for a modicum of disinterested distance from his distress, so that he can appreciate a plan and course of treatment. (b) The transference occurs, at first, at various levels of unconscious mental life and gradually (though never entirely) becomes apparent to the analysand as he creates a picture of his past, often enhanced by clues and explanations provided by the analyst (observations of what the analysand is doing -- including resisting participating in analysis – interpretations, and reconstructions). The transference is both consciously monitored and unconsciously experienced by the analyst. Countertransference reactions provide him with clues about inexplicit (unconscious) trends in the transference. Finally, there are considerations of (c) the real relationship between the two participants that (perhaps grudgingly) have to be admitted to and dealt with by introducing "parameters" to the analytic situation.

Laing appreciated the place of all three elements of the therapeutic relationship in classic psychoanalysis and this is not surprising given his background, but what emerges as central in Laing and, I would argue, in all a genuine psychotherapy (no matter what we call it) is the real relationship between the psychotherapist and the Other. This emphasis follows from Laing's existential-phenomenological orientation.

For Laing (and so, for the therapeut), the establishment and maintenance of the therapeutic alliance depends upon how the real relationship is experienced by both the psychotherapist and his other. Laing differed from most psychotherapists in his view of the nature and meaning as well as the therapeutic uses of the real relationship, in connection with which, as he observed (quoted above) a "*therapist may allow himself to act spontaneously and unpredictably . . . giving orders, laughing, shouting, crying, even getting up from that sacred chair.*" Again, we ask, are these expressions merely excesses, dangerous consequences of

15 A symposium on Laing, "R.D. Laing in the Twenty-first Century," was held at Wagner College, hosted by the author, on October 23-25, 2013.

inadequate training or even psychopathology in the therapist? Critics of Laing himself have suggested this.

I would argue that such charges (which have been levelled at many other psychotherapists, including Sandor Ferenczi, Wilhelm Reich and Jacques Lacan, by fellow members of the guild of psychoanalysts and psychiatrists) belie a lack of candour, if not disingenuousness, on the part of critics. If so many psychotherapists practice in a way that makes them appear chilly and distant from their patients or clients, it is not difficult to see them as being outfitted in the long white jacket of the medical clinician, no matter how they are dressed.

Central to considerations of the real relationship – perhaps better termed the *existential* relation -- is the question of how revealing of himself a psychotherapist should be with the Other. Discussions of the psychotherapist's self-disclosure have been in the air at least since the time of Ferenczi, who advocated what was initially called a more "active" form of psychoanalysis than Freud would permit (at least in theory and in print). More recently, beginning with Carl Rogers, measured revelations of the details of the therapist's life have been considered appropriate, beneficial and even necessary for effective "client-centered" treatment (Rogers, 1965).[16]

But what about those therapists whose personal needs are actually placed before those of the client? There are such. The examples of therapists whose personal lives have overshadowed, or unevenly and unfairly blended with their work are well known and are rightly cited as being good reasons for tightening regulations for licensing clinical psychologists in the United States and elsewhere, and even for raising doubts among the public about the safety of the psychotherapeutic setting. The giveaway here, however, is the adjective 'clinical'. The therapeut's consulting room is not a clinic. The therapeut is not a physician. As we have seen, he never was and was from the start distinguished from the practitioner of the *ars muta*.

Moreover, there is a difference between transgression and the revelation of one's shared humanity and existential fate as a therapist in the presence of the Other. It will always be difficult to determine whether a grandiose delusion is masking as therapeutic zeal. For example, is a psychotherapist who denies, in principle, the usefulness of the concept of psychopathology hiding a serious, albeit ego syntonic, psychological disturbance of his own that is well defended by a theoretical notion? Is there not a place in psychotherapy for a view (which Laing seems to have held) that, for therapeut and Other alike, apparent peculiarities of behavior are really attempts at self-healing and should not be considered pathological, especially when it is clear that the person is trying to save his sanity (albeit without success) in an evidently pathogenic social situation (for example, the Other's family or the therapeutic situation itself)?

What is therapeutic in psychotherapy, I conclude, is founded on the real relationship between the therapeut and the therapand. None of us is a Freud or a Laing. But that is precisely the point. Imitating one or the other comes to nothing, unless it is the humorous caricature of the (male) psychoanalyst wearing a three-piece suit and (until recently) smoking cigars. So, too, for the female analyst, wearing simple print dress embellished by a single strand of pearls. Nor does one need to sit shoeless and cross-legged across from the Other to be co-present to him or her.

That there was only one Freud and one Laing does not mean some of us are just as passionate as they were about discovering the means of penetrating the complicated, sometimes temporarily disabled lives of individuals who have retreated, to a lesser or greater degree, from the conventionalities of consensual reality or who have lost faith in the capacity

16 For an account of an encounter between Laing and Rogers and Laing's notable differences with humanistic psychology, see Maureen O'Hara's reflection in Mullan (1997), pp. 314-322.

of the word to defer the heavy acceptance of our fundamental isolation from each other as human beings, a given of the human condition.

The genuine psychotherapist or therapeut reaches across a void that has opened up between the Other and his Other, who at that moment is the therapeut. This is accomplished by words alone. With respect to the void, Laing's point seems to be that effective psychotherapy can take place only on condition that both parties experience that void as real, even though it may be for the moment more vivid and critical for one of them. Recall Laing's patient who sensed Laing distancing himself from her. This circumstance entails the possibility that it may be essential, from time to time, that the psychotherapist gets up from his chair, walks across the room, and sits down on the floor in front of his patient to "correct" for the perceived distance. Should he sometimes, with considered and considerate directness, look the patient in the eye and say nothing, not for a split second, but for a minute – or longer? Should he join in a patient's laughing or crying? Should he cry for reasons of his own in response to something said by the Other? At the very least, following Laing, we can say that he should not feel prevented from doing any of these things.

It has been said that the psychotherapist's "instrument" is his personality. Apart from the surgical reference, that does not go far enough. Following Laing, I would say instead that what is therapeutic in a psychotherapist is not his personality, but his presence. Seasoned practitioners agree (if only privately) that regardless of one's theoretical orientation, all effective psychotherapists have (or, better, are) a presence that is difficult to describe. As Laing wrote (quoted earlier): "This presence, so immediate to our sensibility, of the other eludes being pinned down entirely objectively. A few moments ago there was just a body making a few movements. Now, someone is there." We may want to call it charisma. It is the therapeut opening his "present" for the Other.

Less difficult to understand is courage, which is the energy of the therapeut's presence. What sort of courage is this, and what are its sources? We may conjecture about what became of the Therapeutes and (with a few exceptions) therapeuts among the second and third generations of the founder of the "first Viennese school" of psychoanalysis. In bringing up the matter of courage, I am most certainly drawing up an indictment against not only contemporary psychoanalysts but also most of those who have come to identify themselves as clinical psychologists, counsellors, social workers, and the rest – in short, mental health practitioners. What has accounted for the haemorrhage of courage among the modern successors of the Therapeutes?

As described in the Part I of this contribution, first, they were confused with physicians. Since the psychotherapist heals with *who he is in what he says* – more particularly, how he speaks to the Other and how that makes it possible for the Other to speak to him in a different way – his vocation is in direct contrast to that of the physician, who neither speaks nor heals, but rather *intervenes* in such a way that the body can heal itself. When (from time to time) the physician breaks his silence to provide reassurance, he effectively steps out of his role as physician. Applying the medical model in purporting to treat the mind as though it were something like a body, psychiatrists have only deepened the confusion surrounding what is unique about the healing art known as "the therapy of the word."

Second, psychotherapists began to see themselves as comprising a guild or profession. Both psychiatry and psychotherapy became institutions and money-making enterprises. With the formalities of a profession came considerations of its corporate body. These included leadership and questions of orthodox succession, credentialing, patenting of services rendered, and legal and public relations connections with social institutions such as schools, government, manufacturers of pharmaceuticals, and the insurance industry. It

was forgotten that the therapy of the word is a calling – perhaps, as Freud suggested, an "impossible calling" – and that one who practiced the art of the calling was essentially a *unicum* (one of a kind), an *Einzelgänger*.[17]

Third, psychotherapists lost sight of what is therapeutic in the word. As we have seen, it is difficult to say with precision just what *is* therapeutic in the word, but this much is clear: We always have to do with more than the content of the spoken words. We have to do with an *utterance*. The therapy of the word has everything to do with how the therapeut positions himself with respect to the Other in preparing to say something and to execute his utterance. There is something of Bakhtin's (1986) notion of *addressivity* among the conditions of the psychotherapist's speech.[18]

Fourth, psychotherapists became afraid of taking risks. This is perhaps the critical change and where the failure of courage has been most poignant. I see R.D. Laing as exemplary of the therapist of the word because of his willingness to *"allow himself to act spontaneously and unpredictably,"* and that meant taking risks. Mired in orthodoxy and preoccupied with preserving a tradition, schools of psychotherapy have spent most of their energy defending a particular theory of technique, while having little to say about who they are and what they do. We know that Freud was reluctant to publish his papers on technique and evidently withheld some, which he may have destroyed.[19] Training committees at institutes and graduate programs are notorious for failing to take a chance when they hesitate to take in candidates who see what they want to do as answering to a calling.[20]

V

In conclusion, let me briefly speculate about the return of the therapeut, since even given conditions in the world of professional psychotherapy just described, it is my impression that as the century continues more of this odd sort of individual will appear. There is currently no home for them and, like the Therapeutes, there cannot be one, since they, too, are isolates and cut off from the physicians and priests. Like the Therapeutes, they wander in a desert. Existential Bedouins, therapeuts pitch their tents in the desert of our Wasteland. One outpost of our wasteland is cyberspace, and yet, ironically, it may be that those who have an interest in the new Therapeutes will have a chance of finding each other only there. For most, the key words will be 'existential' and 'phenomenology'. Fledgling groups have formed, but as might be expected they readily fragment back into their units. There is no herding cats.

The lifestyle of the ancient Therapeutes is telling. For all but one day of the week they lived apart from each other. On the remaining day, they met, ate and talked. Similarly, the fewest formalities seem optimal for those with an existential-phenomenological orientation. True to this inclination, those who would identify with the orientation remain scattered about, working independently. This is inevitable. The only Freudian was Freud and the only

17 Einzelgänger: A loner, lone wolf, a rogue.

18 Addressivity is "the quality of being directed to someone" (Bakhtin, 1986, p. 95), "the quality of turning to someone" (p. 99). Bakhtin distinguishes an utterance from "the signifying units of a language," i.e., mere words. "Addressivity is inherent not in the unit of language, but in the utterance" (p. 99). He makes it clear that the conditions of addressivity include attunement of the Other to the one who speaks and an expectation in the Other of what is to come to him. The significance of this for the psychotherapeutic setting seems undeniable. The text, originally published in Russian, is from 1952-53.

19 See James Strachey note to the "Editor's introduction" to Freud's Papers on Technique, SE 12, pp. 84-87.

20 In this connection consider the fate of psychoanalysis especially in the States as recounted by Douglas Kirsner (2009), Unfree Associations. Inside Psychoanalytic Institutes.

"Laingian" was Laing himself.[21] Each genuine psychotherapist is *sui generis*. Each species contains only one individual.

There are obvious risks living and working this way, but I think we must consider taking them. I try to imagine Freud's audacity for the first time actually sitting down to talk with a patient in the privacy of his consulting room. We read of Laing having sat down in a padded cell with one of his inpatients at Gartnaval Hospital (Mullan, 1996, p. 316). Neurologists (other than Freud, including Josef Breuer) had spoken intimately with their patients, and psychiatrists (other than Laing) had drawn close to dishevelled, often very dirty, back ward patients (Beveridge, 2011, p. 204). But Breuer withdrew in horror from the implications of what his colleague soon called the transference, and other psychiatrists around Laing did not go on to establish Kingsley Hall, although some followed him there. There was something extraordinary about the persistence of these men that is an element of courage.

Both Freud and Laing wrote about the enormous opposition they faced, and from all accounts, what they said was not an exaggeration. A few others are now following in the tradition of the Therapeutes. It is to be expected that they will also face derision, especially from the guild. Each is an *Einzelgänger*, a loner. This is essential, since it is the very nature of the Other who comes to meet him to be the same.

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Incorporating Evidence-Based Practices into Psychotherapy Training in Clinical Psychology Ph.D. Programs in the United States

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Submitted 4-Jul-2012: Re-viewed twice: Jul & Aug 2013; Re-submitted and accepted for publication: 31-Dec-2013

Abstract

The movement towards training and practicing empirically supported treatments (ESTs) has stirred significant controversy within the field of psychology. Considering the powerful influence that clinical psychology training programs have in shaping their students' theoretical orientations, career pursuits, and attitudes toward the science-practice divide, there has been little research on how these programs have been responding to the evidence-based practice movement. This study investigates whether training programs' geographic region and level of research emphasis were associated with offering gold-standard training (i.e., both didactic course and supervised practicum) in ESTs. Associations between a program's perceived obstacles and advantages to the incorporation of ESTs and their likelihood of offering gold-standard training were also assessed. Contrary to our hypothesis, results showed no association between research emphasis and the incorporation of ESTs into training. Programs in the Northeast and West offered the gold standard training in a greater number of ESTs than did schools in the South and Midwest. Programs in the Northeast and the South were more research-oriented than programs in the Midwest. Implications for future research and limitations are discussed.

Key words: evidence-based practice; empirically supported treatments; psychotherapy training; clinical psychology Ph.D. programs

Das Aufnehmen von Evidenz-Basierter Praxis in die Psychotherapieausbildung, im Programme des klinischen Psychologie Ph. D, in der USA
Zusammenfassung

Die Bewegung in Richtung Ausbildung und Praxis durch die Daten der empirisch unterstützten Behandlung, hat innerhalb des Psychologieberufes, signifikante Kontroversen ausgelöst. Wir berücksichtigen die mächtige Beeinflussung, die das klinische Psychologie Ausbildungsprogramm hat, im Ausformen der theoretischen Orientierungen von Studierenden. Deren Kariere Planung und die Ansichten zur Trennung von Wissenschaft und Praxis, werden weiter beeinflusst. Es gibt wenig Forschung über das „wie" diese

International Journal of Psychotherapy: 2014, Vol. 18, No. 2, pp. 21-38: ISSN 1356-9082
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Programme, auf die Evidenz-Basierte Praxisbewegung reagierten. Diese Untersuchung fragt, ob Ausbildungsprogramme verschiedener geographischer Regionen und deren Ebene der Forschungsbewertung im Verbund mit dem Angebot von Goldstandart Ausbildung (im Didaktischen Kurs und supervisierten Praktikum) in ESTs, unterschiedlich sind. Die Verbindungen zwischen den wahrgenommenen Schwierigkeiten eines Programmes, die Vorteile der Integrierung von ESTs und der Wahrscheinlichkeit, Gold Standard Ausbildung zu offerieren, wurden untersucht. Die Resultate, entgegen unserer Annahmen, zeigen keine Verbindung zwischen der Gewichtung von Forschung und der Eingliederung von ESTs in die Ausbildung. Programme im Nordwesten und Westen offerieren das Goldstandart Training in grösseren Zahlen, als Schulen im Südwesten und Mittleren Westen. Programme in Nordosten und Süden waren forschungsorientierter als Programme im Mittleren Westen. Die Implikationen für eine zukünftige Forschung, und deren Limitationen, werden diskutiert.

Schlüsselwörter: Evidenz Basierte Praxis, Empirische Unterstützte Behandlung, Psychotherapie Ausbildung, Klinische Psychologie Ph. D. Programme.

Les Pratiques basées sur des preuves intégrées dans les formations psychothérapeutiques des programmes doctoraux en Psychologie Clinique aux Etats-Unis

Résumé

La tendance vers la formation et la pratique des traitements supportés empiriquement (ESTs) a remué une controverse substantielle au sein du champ de la psychologie. Malgré l'influence puissante des programmes de formations en psychologie clinique dans l'évolution des orientations théoriques des étudiants, la poursuite de leur carrières, et leurs attitudes envers la division science-pratique, il y a eu peu de recherches sur la façon que ces programmes répondent au mouvement prônant une pratique basée sur des preuves. Cette étude cherche à savoir si la région géographique du programme de formation et le niveau d'importance donnée à la recherche étaient associés à une offre de formation talon-d'or (c'est-à-dire, ET le cours didactique, ET le *praticum* surveillé) dans les ESTs. Les associations entre les obstacles et les avantages perçues d'un programme par rapport à l'intégration des ESTs et leur chance d'offrir une formation talon-d'or ont également été évalués. Des programmes dans le Nord-est et l'Ouest offraient la formation talon d'or dans un plus grand nombre d'ESTs que dans les écoles dans le Sud et le Centre-ouest. Les programmes dans le Nord-est et le Sud étaient davantage orientés sur la recherche que les programmes dans le Centre-ouest. Des idées pour des recherches à l'avenir et leurs limitations sont discutées.

Mots-clés : pratique basée sur des preuves ; traitements supportés empiriquement ; formation psychothérapeutique ; programmes doctoraux en psychologie clinique

Включение научно обоснованных методов и подходов в обучение психотерапии в рамках кандидатских программ по клинической психологии в Штатах

Резюме

Движение по включению в обучение и использование на практике *эмпирически подкрепленных методов лечения* (ESTs) вызвало серьезную полемику в психологических кругах. Принимая во внимание мощное влияние обучающих программ на формирование теоретической ориентации студентов, поиски рода деятельности и их установки относительно разделения теория-практика, было проведено мало

исследований того, как эти программы подготовки соотносятся с движением по использованию на практике научно обоснованных методов. В данной работе изучается, предлагались ли в обучающих программах различных географических регионов, а также программах, в различной степени опирающихся на научные исследования, тренинги «золотого стандарта» (например, тренинги, включавшие в себя как дидактический курс, так и супервизируемую практику в рамках ESTs). Оценивались также препятствия и преимущества включения ESTs в программу и вероятность интеграции тренинга «золотого стандарта» в систему обучения. Вопреки нашей гипотезе полученные результаты не обнаружили связи между ориентацией обучающей программы на исследования и включением в нее ESTs. Школы Северовостока и Запада гораздо больше использовали тренинги золотого стандарта, чем школы на Юге и среднем Западе. Обучающие программы на Северовостоке и Юге были больше ориентированы на исследования, чем программы на среднем Западе. В статье обсуждаются предпосылки для будущих исследований и их ограничения.

Ключевые слова: научно обоснованная клиническая практика, эмпирически обоснованные методы лечения, тренинг по психотерапии, кандидатские программы по клинической психологии

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Introduction

The movement towards empirical bases of psychotherapy has stirred significant controversy within the field of clinical psychology, with professionals forming conflicting opinions regarding the roles that evidence-based practices (EBPs) should play in clinical decision-making. The majority of studies on the topic of EBPs have examined various ways of defining "evidence," the suitability of empirically supported treatments (ESTs) for clinical practice, and the various mechanisms responsible for therapeutic change (Silverman, Kurtines & Hoagwood, 2004). Comparatively little research has investigated the more applied aspects of this topic, such as dissemination efforts, effects on clinical practice, or incorporation of ESTs into training programs (Silverman, et al., 2004; Weissman, et al., 2006).

The field is dominated by a scientist-practitioner model that encourages the integration of scientific results into clinical work (Mellott & Mehr, 2007) The majority of today's clinical psychology training programs follow this model (Horn, et al., 2007). However, most programs adopt either a primarily research or clinical orientation (Stricker, 2000) resulting in the production of *either* researchers or clinicians, while Ph.D. programs, despite their mandate to promote psychological research, seem to be producing more clinicians than researchers (Horn et al., 2007; Norcross, Karpiak & Santoro, 2005).

It is likely that the relative emphasis that a program places on either research or practice plays a crucial role in the future career paths of its graduates. For instance, evidence suggests that a program's position on the science-practice continuum is related to students' theoretical orientations and attitudes about the value and feasibility of integrating research findings into their clinical work (Luebbe, et al., 2007; Stewart & Chambless, 2007). The real-world implications of this are extremely important because, if trainees in programs that emphasize clinical work are less exposed to EBPs than trainees in programs that emphasize research, the EBP movement would be operating in a self-contained cycle whereby research inspires further research but has little impact on clinical practice. Considering the powerful influence that clinical psychology programs have in shaping their students, it is surprising that there has been so little research on the ways in which these programs have been responding to the EBP movement.

The limited research that has focused on clinical psychology Ph.D. training programs includes examinations of differences in theoretical orientations, geographic locations, and faculty publication rates. Wisocki and colleagues (1994) conducted a study on theoretical orientations of clinical psychology Ph.D. training programs and found that the most frequent primary theoretical orientation was cognitive-behavioral (55%), followed by psychodynamic (23%), applied behavioral analysis (11%), humanistic-existential (10%), and systemic (8%). Another study, which examined the relationship between a program's theoretical orientation and geographic location, found that the majority of psychodynamic programs are located in large metropolitan areas, particularly in New York City (Nevid, et al., 1986). While anecdotal evidence indicates that Ph.D. programs in the Northeast primarily have a psychodynamic orientation, this is the only documentation of the relationship between a training programs' region and its theoretical orientations in the past 20 years. Finally, a great deal of research on clinical psychology training programs has been devoted to different methods of evaluating a program's impact or achievement, most of which is based upon faculty publication rates (Kadzin, 2000). While these ranking systems are often equated with a program's stature and reputation (Ilardi et al., 2000; Stewart, Roberts, & Roy, 2007), they usually do not include clinical variables – such as, how many faculty members are licensed clinicians, or how many hours of clinical supervision do faculty members provide to students (Cornell, 2008).

In recent years, two studies have empirically examined the degree to which the EBP movement has affected psychotherapy training programs. Woody, Weisz, and McLean (2005) found that clinical psychology doctoral programs (n = 136) and internships (n = 184) were more likely to include ESTs in coursework than in supervision; however, because this study did not differentiate between *available* and *mandated* supervision in ESTs, the degree to which students were actually receiving training in such approaches remains unknown. The main obstacles to the incorporation of ESTs were uncertainty about how to conceptualize training in ESTs, lack of time, shortage of trained supervisors, inappropriateness of established ESTs for specific populations, and theoretical opposition (Woody, et al., 2005).

In a study of programs spanning multiple mental health disciplines, Weissman and colleagues (2006) investigated training and supervision in ESTs offered by accredited training programs in psychiatry (n = 73), Ph.D. clinical psychology (n =63), Psy.D. psychology (n = 21), and social work (n = 64). Results indicated that, while many programs offered didactic courses in ESTs, only a minority required both a didactic and a supervised practicum in such therapies (Weissman et al., 2006). The field with the most types of training – both inside and outside of the classroom – was psychiatry (96% of programs), followed by Ph.D. psychology programs (56%), social work programs (38%), and Psy.D. psychology programs (33%). Overall, results implied that while students learn about various ESTs in classroom settings, they often do not have practical opportunities to perform and receive supervision in such therapies. Furthermore, programs most oriented toward clinical work (i.e., Psy.D. and social work) were least likely to be providing adequate training in ESTs. Results from this study and Woody et al. (2005) indicate that programs are not providing adequate training in ESTs and that programs placing an especially large emphasis on clinical work have the *furthest* to go in developing EST equipped clinicians.

While the above studies that have examined the extent to which training programs have adopted an EBP model, none have investigated the factors that determine whether or not programs incorporate ESTs into their training. These overlooked factors – the *how* and *why* – are central to the research on the impact of the EBP movement. Silverman and colleagues (2004) pointed out that *"there is a critical need to identify and evaluate the mechanisms of*

adoption of ESTs" (p. 297) and to investigate how EST dissemination and adoption is affected by contextual factors. The same critical need exists within the more specific framework of graduate training programs, as the reasons underlying the differential rates of EST adoption among graduate programs remain unknown.

So, why do some graduate programs incorporate ESTs into their training while others do not? One potential factor may be a program's placement along the continuum of research and practice emphasis. While many studies have documented the relative research versus clinical emphasis of clinical psychology training programs through the analysis of scholarly publication rates (e.g. Roy, et al., 2006; Stewart, et al., 2007), no study has examined whether the level of research emphasis is related to the incorporation of ESTs into training.

There is evidence that a program's research or clinical emphasis might affect its adoption of ESTs. Stewart and Chambless (2007) found that graduate training programs exert a potent influence on attitudes toward EBPs, as clinicians who reported that their graduate program emphasized research were more likely to value and use research evidence in their clinical decision-making. Furthermore, a study of graduate students found that, when compared to their peers who intended to pursue a career in research, students who intended to pursue a career in clinical practice reported more resistance to the principles of EBPs and a lower likelihood of incorporating ESTs into their work (Luebbe, et al., 2007). Such results imply that among practicing psychologists, emphasis on clinical practice and incorporation of ESTs are inversely related; however, the degree to which these factors are related in graduate programs remains unknown.

Against the backdrop of the EBP movement, whose goal is the incorporation of EBPs into clinical work (APA Presidential Task Force on Evidence-Based Practice, 2006), the general conclusion from the aforementioned studies is noteworthy. Results imply that individuals pursuing a career in practice are less likely to incorporate research evidence into their treatments. This trend is representative of the more general research-practice chasm in clinical psychology (Luebbe, et al., 2007). If the relationship between research emphasis and interest in ESTs in training programs reflects that of practitioners in the community, then the paradox between the stated intention and actual effect of the EBP movement becomes even more apparent; that is, if the predominantly research-oriented programs are more likely to train their students in ESTs than are the more clinically-oriented programs, the EBP movement would seem to be fueling a great deal of research into ESTs, but would be having a very small effect on actual practice.

A second category of questions remains about the regional differences between psychotherapy training programs. While popular belief suggests that programs in Northeast America primarily have a psychodynamic orientation, and are less likely to focus on research, this assumption is in need of further empirical investigation as no studies in the past two decades have systematically examined the relationship between geographical differences and incorporation of ESTs among clinical psychology Ph.D. training programs.

Finally, factors related to perceived obstacles and advantages of incorporating ESTs into clinical psychology Ph.D. programs need to be identified. Firstly, some clinical programs do not want to incorporate such training, as their faculty members or clinical training directors believe that an EST approach is overly rigid, dehumanizes clients, or impinges autonomy (Pagoto, et al., 2007; Woody, et al., 2005). Espousing this point of view, Henry (1998) argues that the incorporation of ESTs into graduate programs narrows clinical treatment options, downplays the interpersonal factors that are linked with outcome, and dramatically reduces the overall quality of training. Secondly, even in programs that *want* to incorporate ESTs, there are various barriers to implementation, including insufficient time to teach ESTs,

shortages of supervisors trained in ESTs, and lack of trainee interest (Weissman, et al., 2006; Woody, et al., 2005). However, more information is needed to understand which factors are related to the endorsement of such obstacles by some programs but not by others.

While there are a multitude of barriers to incorporating ESTs into practice and training, there are also many facilitators of this process. In a survey examining advantages of integrating ESTs, many training directors cited that ESTs are easy to teach, economical, and lead to better patient care (Weissman, et al., 2006). In fact, a recent study found that the shift from non-ESTs to ESTs (for a variety of clients in an outpatient community clinic) was associated with enhanced treatment outcomes (Cukrowicz, et al., 2005). Just as there is a dearth of research on the reasons underlying barriers to implementation, many questions remain regarding facilitators of implementation. It is important to know if there are factors distinguishing programs that see advantages of teaching ESTs from those that do not.

The goal of the current study was to investigate relationships between clinical psychology Ph.D. programs' level of research emphasis and geographical location, and offering gold-standard training in ESTs. First, we hypothesized that programs' research emphasis will predict the number of perceived obstacles and advantages, such that highly research-emphasized programs would be less likely to endorse obstacles to the incorporation of ESTs and more likely to endorse advantages than programs with low research emphasis. Second, we sought to investigate regional differences in the level of research emphasis between programs and the number of perceived obstacles and advantages when including ESTs into training. Given the dearth of prior data on regional differences, analyses were exploratory and no *a priori* hypotheses were made. Finally, we sought to determine which factors (i.e., research emphasis, perceived obstacles and advantages, and geographical location) predict whether a program offers gold-standard training in ESTs and factors associated with the number of ESTs offered meeting the gold-standard training.

Method

Sample: The sample for this study included 62 directors of clinical training of APA-approved clinical psychology Ph.D. programs that participated in the survey by Weissman and colleagues conducted in 2004 (Weissman, et al., 2006). A total of 150 clinical psychology Ph.D. programs were identified from the accreditation roster of the APA. The programs were classified by their geographical location (Northeast, West, South, and Midwest). A stratified random sample of 54.4% of programs was selected with proportional allocation among the four regional strata to ensure sufficient number of programs in each region so as to make meaningful comparisons. The directors of clinical training were identified through university websites or by contacting the clinical training programs. If the listed director had changed, the new one was contacted.

The survey began in May 2004 and ended in December 2004, when more than a 70% response rate was procured. The response rate from clinical psychology Ph.D. programs was 76.8% (as compared to 73.7% for psychiatry residency programs, 70% for Psy.D. programs, and 71.9% for social work programs). The final sample for this study included 12 training directors from schools in the West (19.4% of the sample), 21 from the South (33.9%), 16 from the Midwest (25.8%), and 13 from the Northeast (21%).

Procedure: A brief report of the methodology most relevant to the current study follows. For a detailed report of the methodology utilized in the national survey, see Weissman et al. (2006). Although the national survey provided data on psychiatry, clinical psychology Ph.D., clinical psychology Psy.D., and social work, this article solely examines findings from the

clinical psychology Ph.D. data.

National Survey of Psychotherapy Training: First, a pilot survey was conducted to identify which psychotherapeutic approaches were currently offered in accredited clinical psychology, psychiatry, and social work training programs. Based on the results of the pilot survey, a draft set of questions was developed and reviewed by experienced trainers and psychotherapy experts. The survey was completed by the directors of clinical training who were asked to indicate whether particular psychotherapeutic approaches were taught, whether they were required or elective, and whether they were covered in lecture/class work (didactic) and/or in supervised clinical work. The survey was web-based, although it could be mailed or faxed to the respondent, if preferred. The survey took about 10 to 15 minutes to complete and was approved by the New York State Psychiatric Institute Institutional Review Board.

The final survey consisted of the following sections: 1) a list of 23 different psychotherapies, of which seven were ESTs, in which respondents were to check off whether the psychotherapy was offered as a didactic and/or clinical supervision and whether each was required or merely offered; 2) space for respondents to provide additional psychotherapies not listed as ESTs and to provide an alternative definition of ESTs; 3) a list of obstacles (e.g., "not relevant," "do not have qualified faculty") and advantages (e.g., "better patient care," "trainee interest") to training students in ESTs, in which respondents were to check off all that apply; and 4) space for respondents to provide additional obstacles and advantages.

Empirically-supported therapies were defined briefly on the form as manualized psychotherapies tested in at least two randomized controlled trials. The classification of a treatment as an EST also required that the trials have samples of sufficient power with well-characterized patients with specific psychiatric disorders; randomly assigned control conditions of psychotherapy, placebo, pill, or other treatment; and at least two different investigative teams demonstrating efficacy. This definition was close but not identical to that proposed by Chambless and Ollendick (2001).

The list of 23 psychotherapies, included the following seven ESTs: behavior therapy, cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), family therapy (manual-based), interpersonal therapy (IPT), multi-systemic therapy, and parent training. The 16 non-ESTs were: case management, couples therapy, existential psychotherapy, family therapy (general), forensic psychotherapy, general psychotherapy (unspecified), gestalt psychotherapy, group psychotherapy, humanistic psychotherapy, milieu psychotherapy, psychoanalytic/psychodynamic psychotherapy, psycho-education, short-term/time-limited psychotherapy, social work counseling, substance abuse counseling, and supportive psychotherapy. The respondents were asked to indicate whether the therapy was offered as a didactic, whether it was offered as a clinically supervised practicum, and whether it was required or elective. Respondents could also provide their own definitions of EST.

Research emphasis: Research emphasis of the programs that participated in the survey was measured based on Stewart and colleagues' (2007) ranking of the scholarly productivity of 166 APA-accredited Ph.D. clinical psychology programs. The list of 166 programs was obtained from the list of accredited APA clinical psychology programs for 2004. The research emphasis ranking was assessed based on programs' mean number of core faculty members' scholarly journal publications listed in the PsycINFO database over a five year period (2000-2004), with the highest mean number of publications associated with the highest ranking (#1) and the lowest mean number of publications associated with the lowest ranking (#166). Scholarly journal publications were defined as those articles that were published in peer-reviewed journals (Stewart, et al., 2007).

In order to protect the confidentiality and anonymity of respondents to the Weissman et al. (2006) study, we then transformed research emphasis into an ordinal trichotomous categorical variable as follows: programs in the top third of the ranking were labeled "High," programs in the middle third of the ranking were labeled "Medium," and programs in the bottom third of the ranking were labeled "Low."

Classification of incorporation of evidence-based training

The study utilized Weissman and colleagues' (2006) definition of "Gold Standard Training." For each of the seven ESTs, a program was considered to offer gold-standard training if a didactic and supervised practicum were both required (1 = yes, 0 = no).

Geographic region: Each program was classified by geographic region: Northeast, West, South, and Midwest.

Obstacles and advantages to training students in ESTs: Respondents were asked to check off as many of the obstacles and advantages to training students in ESTs that they believed were relevant. The list of advantages included: "better patient care," "economical," "easy to teach," "targeted to disorders," "trainee interest," "training materials available," "brief/time-limited," and "third party reimbursement." The list of obstacles included: "lack of trainee interest," "too difficult to teach," "do not have qualified faculty," "funds unavailable," "too time-consuming," "not relevant," "need more evidence," and "does not work in clinical practice."

Statistical analysis: We first calculated descriptive statistics (frequencies and proportions) for all variables used in the models. Chi-square tests were performed to examine regional differences in different types of ESTs. If 20% or more of the cells had expected count less than 5, Fisher's exact test was used. We then conducted an ordinal logistic regression to examine whether there were regional differences among surveyed programs in their level of research emphasis. Linear regression analyses were conducted to identify predictors of the number of perceived obstacles and advantages to incorporating ESTs into training. Another set of linear regression analyses was performed to identify factors associated with the number of EST offered with gold-standard training. Finally, a set of logistic regressions was conducted to examine significant predictors of incorporation of ESTs into training. It should be noted that, despite recent evidence suggesting that some types of psychodynamic therapy are empirically supported (Leichsenring & Rabung, 2008), in our survey we were unable to differentiate between the non-EST versions of psychoanalytic/psychodynamic therapy and the more empirically-supported forms. Thus, for the purposes of our paper, psychodynamic therapy was not considered an EST and was not included in our analyses.

Results

Descriptive Analyses: Table 1 presents the research emphasis of surveyed institutions by geographical region. The majority of high research-focused programs were from the Northeast, and most low research-focused programs were from the Midwest. Table 1 also presents the total number of perceived obstacles and advantages to teaching ESTs for the total sample and by geographic region. The most frequently perceived obstacles for the total sample were "lack of trainee interest" and "do not have qualified faculty," while the most frequently perceived advantages were "easy to teach," "economical," and "better patient care."

Other perceived obstacles included a perceived gap between EBT guidelines and the reality of clinical practice in community settings (27%) and skepticism – particularly among senior faculty member – about the utility/evidence of ESTs (14%). Other perceived advantages were that training in ESTs is consistent with the scientist practitioner model (30%) and is more ethical (20%). Overall, 30.6% of training directors perceived at least one obstacle, though

the majority (54.8%) did not perceive any obstacles to teaching ESTs in graduate training. Additionally, 93.5% of the programs perceived at least one advantage, and about half (54.8%) perceived at least five of the eight advantages to teaching ESTs in graduate training (data not shown).

Table 1: *Descriptive characteristics for surveyed programs by geographic region.*

	Total (n = 62)	Northeast (n = 13)	West (n = 21)	South (n = 16)	Midwest (n = 12)
	f (%)	*f* (%)	*f* (%)	*f* (%)	*f* (%)
Research Focus†					
High	20 (32.3)	8 (61.5)	3 (25.0)	7 (33.3)	2 (12.5)
Medium	21 (33.9)	2 (15.4)	5 (41.7)	9 (42.9)	5 (31.3)
Low	21 (33.9)	3 (23.1)	4 (33.3)	5 (23.8)	9 (56.3)
Obstacles†					
Lack of trainee interest	16 (25.8)	4 (30.8)	3 (25.0)	3 (14.3)	6 (37.5)
Do not have qualified faculty	7 (11.3)	2 (15.4)	0 (0.0)	2 (9.5)	3 (18.8)
Too difficult to teach	6 (9.7)	0 (0.0)	2 (16.7)	1 (4.8)	3 (18.8)
Funds unavailable	4 (6.5)	0 (0.0)	1 (8.3)	1 (4.8)	2 (12.5)
Does not work in clinical practice	3 (4.8)	0 (0.0)	1 (8.3)	2 (9.5)	0 (0.0)
Too time-consuming	2 (3.2)	2 (15.4)	0 (0.0)	0 (0.0)	0 (0.0)
Need more evidence	1 (1.6)	0 (0.0)	0 (0.0)	0 (0.0)	1 (6.3)
Not relevant	1 (1.6)	0 (0.0)	1 (8.3)	0 (0.0)	0 (0.0)
Other	15 (24.2)	3 (23.1)	1 (8.3)	7 (33.4)	4 (25.0)
Advantages					
Easy to teach	48 (77.4)	10 (76.9)	8 (66.7)	17 (81.0)	13 (81.3)
Better patient care	45 (72.6)	7 (53.8)	10 (83.3)	16 (76.2)	12 (75.0)
Economical	45 (72.6)	12 (92.3)	6 (50.)	17 (81.0)	10 (62.5)
Targeted to disorders	43 (69.4)	7 (53.8)	8 (66.7)	16 (76.2)	12 (75.0)
Trainee interest	37 (59.7)	7 (53.8)	6 (50.0)	13 (61.9)	11 (68.8)
Brief/time-limited	27 (43.5)	7 (53.8)	3 (25.0)	9 (42.9)	8 (50.0)
Training materials available	21 (33.9)	5 (38.5)	4 (33.3)	7 (33.3)	5 (31.3)
Other	10 (16.1)	1 (7.7)	1 (8.3)	7 (33.3)	1 (6.2)

Table 2: *Percent of Schools Offering Gold Standard Training in ESTs.*

Gold Standard Training	Total (n = 62)	Northeast (n = 13)	West (n = 12)	South (n = 21)	Midwest (n = 16)		
	f (%)	*f* (%)	*f* (%)	*f* (%)	*f* (%)	χ^2	*p*
EST							
CBT	32 (53.2)	7 (53.9)	9 (75.0)	9 (42.9)	8 (50.0)	3.26	0.35
Behavior Therapy	21 (33.9)	6 (46.2)	4 (33.3)	47 (33.3)	4 (25.0)	1.44	0.69[a]
Parent Training	7 (11.3)	4 (30.8)	2 (16.7)	1 (4.8)	0 (0.0)	6.76	0.03[a]
IPT	6 (9.7)	2 (15.4)	3 (25.0)	0 (0.0)	1 (6.3)	5.11	0.05[a]
Family Therapy	3 (4.8)	1 (7.7)	1 (8.3)	1 (4.8)	0 (0.0)	0.91	0.60[a]
DBT	2 (3.2)	1 (7.7)	1 (8.3)	0 (0.0)	0 (0.0)	3.06	0.22[a]
Any EST	35 (56.5)	8 (61.5)	9 (75.0)	10 (47.6)	8 (50.0)		

Note. EST = Empirically-supported treatments; Multi-systemic therapy was excluded from the table as its frequency was 0% in the sample.

[a] Fisher's exact test

Table 2 shows the rates of gold-standard training in each EST by geographic region. Overall, 56.5% of programs (n = 35) met the gold-standard training in any EST. Schools in the West had the highest rates of EST training in all treatment modalities, except behavioral therapy and parent training, which were highest in Northeastern programs.

Geographic Region and Research Emphasis: Level of research emphasis differed significantly by geographic region, $\chi^2(3, N = 62) = 8.724$, $p = .03$. Test of parallel lines showed no violation of the proportional odds assumption, $\chi^2(3, N = 62) = 2.268$, $p > .05$. Pair-wise comparisons indicated that compared to programs in the Midwest, programs in the Northeast were 8.5 times (95% CI; 1.92, 36.67) as likely to rank higher in research emphasis ($\beta = 2.13$, s.e. = .75, $\chi^2(1, N = 62) = 7.98$, $p = .005$), and programs in the South were 3.6 times (95% CI; 1.02, 12.64) as likely to rank higher in research emphasis ($\beta = 1.28$, s.e. = .643, $\chi^2(1, N = 62) = 3.941$, $p = .047$).

Predictors of Number of Perceived Obstacles and Advantages of Incorporation of ESTs into Training

Research focus: We hypothesized that programs with a greater emphasis on research would be less likely to endorse obstacles and more likely to endorse advantages. However, research emphasis did not significantly predict endorsement of obstacles ($F(2,59) = .989$, $p > .05$) or advantages ($F(2, 59) = .192$, $p > .05$).

Geographic Region: We also hypothesized that geographic region would influence the program's endorsement of obstacles and advantages. However, geographic region was not significantly associated with perceived obstacles ($F(3,58) = .1.095$, $p > .05$) or advantages ($F(3, 58) = .296$, $p > .05$).

Predictors of Incorporating ESTs into Gold-standard Training

The following variables were tested as potential predictors of incorporation of ESTs into graduate clinical psychology training: program research emphasis, geographic location, and perceived obstacles and advantages to implementing of gold-standard training in ESTs. Due to small sample size (n = 62), the study did not have sufficient statistical power to model all factors simultaneously. Following Harrell's recommendations (2001), we looked at each predictor separately.

Number of obstacles and advantages: We conducted two binary logistic regressions, one with number of perceived obstacles as the independent variable, and the other with number of perceived advantages. Results showed a statistically significant effect of number of perceived obstacles, (OR = .37 95% CI; .18, .766, $p = .008$). That is, for each additional obstacle endorsed, likelihood of offering gold-standard training in ESTs is reduced by approximately more than one third. On the other hand however, there was only a marginal effect for the perceived advantages (OR = 1.23, CI; .98, .1.53 $p = .068$).

Subsequently, we conducted chi-square tests to examine which perceived obstacles and advantages were associated with whether programs offered gold-standard training in ESTs (data not shown). The only obstacle significantly associated with gold-standard training was "unavailable funds": none of those who perceived this obstacle offered gold-standard training in ESTs, whereas 60.3% (n = 35) of those who did not endorse this obstacle offered gold-standard training in ESTs ($\chi^2 = 5.543$, $p = .031$; Fischer's correction). The only advantage significantly associated with gold-standard training was "better patient care": of those who perceived this advantage, 64.4% (n = 29) of programs offered gold-standard training in ESTs, as opposed to

35.3% (n = 6) of those who did not endorse this advantage (χ^2 = 4.265, p = .039).

Research emphasis: Results from a binary logistic regression analysis with research emphasis as the independent variable showed no statistically significant effect of a program's research emphasis on whether it offers gold-standard training in ESTs , $\chi^2(2, N = 62) = 2.58$, $p > .05$.

Geographic region and incorporation of ESTs into training: Another binary logistic regression analysis was conducted with geographic region as the independent variable. Results showed no statistically significant effect of geographic region, $\chi^2(3, N = 62) = 2.85$, $p > .05$.

When examining regional differences separately for each type of EST, chi-square test showed that there was a statistically significant relationship between geographic region (Northeast, West, South, and Midwest) and gold-standard training offered in Parent Training and a marginal association between geographic region and gold-standard training for Interpersonal Psychotherapy (see Table 2). Twenty five percent of programs in the West, and 15.4% of programs in the Northeast offered gold-standard training in IPT contrary to 0% and 6.3% of programs in the South and Midwest respectively. Parent training was more available as gold-standard training in programs in the Northeast (30.8%), followed by the West (16.7%). In the South, parent training was offered in only one program (4.8%), whereas no programs offered it in the Midwest.

Predictors of Number of ESTs offered with Gold-standard Training: To investigate regional differences between psychotherapy training programs, we conducted a linear regression analysis with the dependent variable defined as number of ESTs offered with gold-standard training and the programs' geographic region, research emphasis, and number of perceived obstacles and advantages as the independent variables. There was a significant geographic region effect, such that programs in the Northeast and the West offered gold-standard training in a greater number of ESTs compared to programs in the South and the Midwest, $t(59) = 3.072$, $p = .013$ (See Table 3).

Table 3: *Multiple linear regression results*

	B	s.e.	β	*t*	*F*(7, 54)	R^2
Obstacles	-.205	.197	-.131	-1.042	2.779*	.265
Advantages	.125	.067	.230	1.872†		
Research Emphasis						
Middle versus High and Low	-.137	.112	-.147	-1.224		
High versus Low	-.217	.205	-.134	-1.058		
Geographic Region						
Northeast/West versus South/ Midwest	.498	.162	.371	3.072**		
North versus West	.189	.252	.091	.748		
South versus Midwest	-.154	.213	-.090	-.725		

†$p < .1$;*$p < .05$; **$p < .005$.

Discussion

This study was the first to investigate relationships between training programs' level of research emphasis, geographic location, and incorporation of ESTs into training within APA-approved clinical psychology Ph.D. doctoral programs. Our results can be summarized as follows: (a) programs in the Northeast and the South had greater research emphasis,

compared to programs in the Midwest; (b) the greater the number of perceived obstacles, the less likely a program was to offer gold-standard training in ESTs; (c) programs in the Northeast and the West appeared to be more likely to offer gold-standard training in Parent Training and Interpersonal Psychotherapy, compared to programs in the South and Midwest; and (d) programs in the Northeast and the West offered gold-standard training in a greater number of ESTs, compared to programs in the South and Midwest.

Contrary to our hypothesis, there was no association between research emphasis and incorporation of ESTs into training. There are multiple possible explanations for this finding. First, it is possible that a program's relative emphasis on research is not an indicator of its dedication to teaching ESTs to its students. Research has indicated that very little is known about the clinical psychology Ph.D. training programs, as the content of courses, nature of practicum training, and standards for empirical and scholarly contributions vary and remain unknown to those outside of each program (McFall, 2006). Relatedly, programs may differ from one another to such a significant degree that a single commonality, such as emphasis on research may not be powerful enough to predict programs' use of ESTs in training. Additionally, APA accreditation standards have demanded that programs incorporate ESTs into training (American Psychological Association, 1996); as a result, it is possible that accredited programs, regardless of their clinical or research emphasis, are more similar than different in their incorporation of ESTs into training. It is also possible that the majority of clinical training, including training in ESTs, actually occurs during clinic supervision, on independent externships, internships, or even at the post-doctoral level. If this were the case, doctoral programs themselves would have little direct impact on the therapeutic approaches that their students choose to practice. Therefore, it may be more important in the future to examine the kind and variety of placement opportunities students take on, when considering the impact of the EBP movement.

Furthermore, it is possible that research-oriented graduate students may be more likely to incorporate ESTs into their work than clinically oriented graduate students, but that these differences do not exist at the program level. In addition, Kazdin (2000) has pointed out that training programs are evolving and, because a training program's philosophy and mission, as well as its faculty members change over time, it is impossible to settle on any static description of a program. It is also possible that research emphasis *is* a reliable predictor of incorporation of ESTs into training, and that the null findings reflect less than optimal operationalization of the level of research emphasis. This was defined using faculty members' scholarly publication rate. The rate was based on the mean number of refereed journal articles listed in the PsycINFO database from core faculty members, published during a five-year period, from 2000 to 2004 (Stewart, et al., 2007). Limitations to this method are discussed below.

With regard to regional differences among programs in research emphasis, we found that programs in the Northeast were more likely to emphasize research overall than are programs in the Midwest. Northeastern schools overall, including those in New York City which are usually perceived as clinically focused, have a comparably high research emphasis as other parts of the U.S., such as the South. This finding contrasts the popularly held belief that Northeastern programs focus on clinical practice to the detriment of research productivity.

In addition, important regional differences were observed with respect to gold-standard training in ESTs. Findings indicated that programs in the Northeast and West offered gold-standard training in greater numbers and variety of ESTs than did programs in the South and Midwest. This finding suggests that programs in the Northeast and West have a greater

dedication to EST training than they are typically acknowledged as having. Moreover, Northeast and West were more likely to offer gold-standard training in IPT than programs in the South and the Midwest. Northeastern programs were more likely than programs in other geographic regions to offer parent training. In addition, findings indicated that many graduate programs teach their students a variety of clinical approaches, suggesting that students are exposed to broad-based learning and are receiving superior training with regards to the breadth of their clinical skills. It is possible that differences among programs between the Northeast and other regions have lessened over the years.

Finally, contrary to what was hypothesized, we did not find any significant relationships between research emphasis and endorsement of obstacles or advantages. This finding might be explained by the directions of the survey, which asked training directors, "What do you see as the obstacles, if any, to training students in evidence-based therapies?" and "What do you see as the advantages, if any, to training students in evidence-based therapies?" The questions leave open to interpretation whether the respondent should check off answers based on what s/he *personally* sees as the obstacles or advantages, or what s/he believes *the field of psychology* sees as the obstacles or advantages. Overall, the frequencies at which training directors perceived obstacles and advantages indicated that the majority of them see few obstacles and many advantages to training students in ESTs. This may have contributed to the null findings, as lack of variability in the dependent variable limits the potential to find significant relationships.

Our findings have identified certain areas of importance when considering the feasibility of incorporating ESTs into training. Though the majority of training directors perceived more advantages than obstacles to providing gold standard EST training, it appears that the existence of these obstacles outweighs the possible advantages. Interestingly, most programs identify "lack of trainee interest" as the primary obstacle to incorporating ESTs into training. Future research should explore doctoral students' actual interest and motivation in receiving training in ESTs. It is possible that many students are more interested in evidence-*based* practices than in ESTs themselves. For example, many practice-oriented students may prefer to focus on adapting treatments to be effective for populations of specific cultural or demographic backgrounds, instead of receiving training in ESTs. Indeed, some researchers have noted the importance of evidenced-informed practice instead of practice *dictated* by evidence, as outcome research using groups do not necessarily generalize to the individual patients seen in clinical practice (Bohart, 2005).

Another important obstacle is that ESTs are not relevant outside of university clinics. This is crucial in the absence of an in-house training clinic, as, according to the surveyed clinical training directors, few community-based practices utilize EBTs. Other obstacles include lack of qualified faculty (particularly when one needs to cover several different types of ESTs, i.e., "can't have an IPT person, a CBT, a DBT, etc.") and lack of ecological validity, particularly when it comes to high diagnostic specificity that sometimes over-simplifies the complex cases students see in a program's practice. Therefore, it may be more crucial for programs, aiming to establish gold standard training, to reduce salient, current obstacles than to advocate the less tangible advantages of EST training.

Limitations

There are limitations to this study, many of which are a function of using data from two existing studies that had been collected between 2000 and 2004 (i.e., Stewart, et al., 2007; Weissman, et al., 2006). As nine years have elapsed since the survey was conducted, there

may have been some shifts within the state of clinical psychology graduate training. Further follow-up studies can compare more recent data to our survey data from 2004 and identify patterns of change in EST-training implementation. In the study by Weissman and colleagues (2006), there may be several characteristics of graduate programs that impact the integration of ESTs into training, such as the programs' financial resources; these characteristics deserve further exploration to understand why such a gap exists. Additionally, to make the survey easier to complete, and therefore more feasible and acceptable, the authors did not assess the quality of didactic instruction. It would be very useful to distinguish between teaching an EST for a *specific disorder* and teaching *general principles* of an EST; depending on the type of didactics, students will emerge from their classes with different types of knowledge and with differential preparation to implement ESTs in clinical practice.

Similarly, it may be useful in future surveys to distinguish between programs that just offer supervisors who practice certain ESTs, and those that also promote externships outside of the program that offer a more holistic EST training. As Maddux and Riso (2007) pointed out, training programs run the risk of providing an imbalanced training (one which doesn't sufficiently meld research and practice) when they rely too heavily on either supervision offered by their own full-time research faculty or supervision under professional clinicians in the field.

In addition, drawing on Weissman et al.'s (2006) clear definition of ESTs in the study, it would be beneficial to define therapies and practica in light of the lack of standardization of definitions in the field of clinical psychology (Leichsenring & Rabung, 2008). Distinguishing which practicum experiences were externship sites, individual supervisors, or group supervision within a program would further clarify the nature of clinical training offered in the surveyed programs. Similarly, specifying further the type of externship placement, whether this is a community mental health center, a hospital, or other mental health treatment setting, might help identify variability in trainees' exposure to ESTs due to wider, organizational influences. For instance, settings offering mental health services reimbursed by health insurance companies may be more pressured to deliver certain ESTs as compared to settings that use a self-pay system, often on a sliding scale.

A second category of limitations involves the use of the Stewart et al. (2007) method of ranking scholarly productivity. These limitations include the definition of "core faculty" which may vary across doctoral programs and therefore affect publication rates (Cornell, 2008), the use of a five-year period in creating the rankings, a period of time in which faculty numbers may change along with associated publication productivity (Andersen, et al., 2008), using only PsycINFO to obtain information on publications (Stewart, et al., 2007), and trichotomizing programs' research emphasis in high, middle, and low research emphasis; of note, the latter was done in order to maximize respondents' anonymity and confidentiality.

A third category of limitations involves the operationalization of the variables in the study. The single metric of scholarly publication rate may not adequately capture the complex construct of research emphasis (Stoltenberg & Pace, 2007). For example, the order of authorship would be an important characteristic to include in assessing quality over quantity of publications. In addition, differentiating between empirical and theoretical publications would further help identify which programs are in fact more research oriented. Moreover, the research emphasis variable was based solely on faculty productivity. Faculty who publish extensively may not be the ones to teach or supervise the most, resulting in little association between faculty productivity and training provided in ESTs. Including student outcomes, such as student publication rates during graduate school and immediately after graduation, which are of high importance in assessing clinical psychology doctoral programs' research-

versus clinical-emphasis, would greatly aid in rating programs' research productivity more accurately (Cornell, 2008).

A final limitation concerns the generalizability of our findings. There are differences in the way Ph.D. programs have implemented the APA's Committee on Accreditation (COA; 1996) requirements for expected graduate student competency levels. As part of a widely accepted "cube" model, 12 competencies have been identified and categorized as foundational and functional competencies (Rodolfa et al., 2005). One competency in the latter category is intervention, the goal of which is *"to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations."* In 2006, APA created an Assessment of Competency Benchmarks Work Group to operationalize each competency and set behavioral anchor points for identifying when students are demonstrating an acceptable level of readiness for practicum, internship, and practice (Fouad, 2009). However, specific methods of measuring these behavioral anchor points are not described, making it hard to assess the various competencies, including intervention. No research to date focuses on Ph.D. programs' experiences integrating such an evaluation system into their didactics or supervisory activities. In addition, the COA (APA, 2006) guidelines indicate that competencies should be commensurate with the specific training model and mission of each program, making it difficult to standardize what type or how much evidence-based treatment training is acceptable.

Implications of this Research

In the last two decades, the field of clinical psychology has been dedicated to researching and establishing empirically based treatments and to debating the value of an EBP approach to psychotherapy; however, during this time period, very little attention has been paid to the ways in which the EBP movement affects the training of the next generation of clinical psychologists.

Future studies that utilize a measure of a program's research emphasis should consider the quantity *and* quality of scholarly publications, the empirical or theoretical nature of the publications, the degree to which publications impact the research community, and the scholarly publication rate of both faculty and graduate students. Such a comprehensive assessment would more accurately capture the degree to which programs focus on research or clinical practice, and provide a clearer picture of the program's overall quality and training goals. Additionally, the evaluation of research- versus clinical-emphasis should not merely be defined based on *research* criteria; as Cornell (2008) suggests, future surveys should ask clinically-oriented questions as well, such as how many faculty members are licensed clinicians, how many hours of clinical supervision faculty members provide to graduate students, or how many patients each faculty member has seen in a given time period. Moreover, researchers and clinicians seem to associate ESTs with time-limited or cognitive-behavioral characteristics. A recent study has established a strong empirical basis for psychodynamic psychotherapy (Leichsenring & Rabung, 2008), implying that the notion of ESTs is truly an umbrella term that encompasses many types of treatments. Future studies should re-address the research questions in this paper using more inclusive methods of measurement and, also, using a larger sample size so as to maximize the likelihood of uncovering significant relationships.

Additionally, longitudinal studies should be conducted to investigate the long-term impact that EST training in graduate school has on post-graduate career decisions. To the authors' knowledge, no study has examined the degree to which aspects of graduate training affects

psychotherapists' incorporation of ESTs into clinical work, decisions to pursue additional EST training, or embracing of a non-EST approach to practice. Future longitudinal studies should also examine the patterns of doctoral programs' movements toward or away from an EBP approach to clinical training to help identify the factors that lead to increased or decreased incorporation of ESTs into didactic and practicum opportunities. Findings from such studies would lead to a more nuanced understanding of the way in which the EBP movement affects training and would help explain the science-practice divide that exists in the field of clinical psychology.

The findings of this study are significant in advancing the field's understanding of the ways in which the EBP movement is affecting the training of future clinical psychologists. In the past 20 years, there has been a surge of research establishing ESTs (APA, 1995; APA Presidential Task Force on Evidence-Based Practice, 2006), documenting their generalizability (Kraemer, 2000; Stirman, et al., 2003), and espousing their application (Barlow, et al., 1999; Hunsley & Lee, 2007); however, the discrepancy between science and practice remains, as the majority of practicing psychotherapists do not incorporate such research into their clinical decision making (Norcross, et al., 2005). The reasons for the gap between research and clinical practice of ESTs are unclear, and it seems likely that certain aspects of training programs – where students are forming their identities as clinical psychologists and deciding on future career paths – may explain the divide.

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We would like to acknowledge that funding from the Josiah Macy Jr. Foundation (Grant 1003551 to Myrna M. Weissman) and NIMH K23 Award (MH071530 to Helen Verdeli) supported this work.

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Why Most Therapists Are Just Average (and How We Can Improve)

Scott Miller in an interview with Tony Rousmaniere[1]

Abstract

Scott Miller (SM) is a contemporary American psychologist and co-founder of the International Center for Clinical Excellence and the Institute for the Study of Therapeutic Change. He co-authored (with Barry Duncan) *The Heroic Client: A Revolutionary Way to Improve Effectiveness through Client-Directed, Outcome-Informed Therapy*. He is also an expert researcher on what makes a good therapist; here – in an interview with Tony Rousmaniere (TR), he breaks down the difference between the best and the rest of us.[2]

Warum die meisten Therapeut nur durchschnittlich sind (und wie können wir besser werden)
Zusammenfassung

Scott Miller ist ein zeitgenössischer Amerikanischer Psychologe und Mitgründer des Internationalen Zentrums für Klinische Vortrefflichkeit, sowie dem Institut zur Studie des therapeutischen Wandels. Zusammen mit Barry Duncan schrieb er: *The Heroic Client: A Revolutionary Way to Improve Effectiveness through Client-Directed, Outcome-Informed Therapy.* Er ist ein Forschungsexperte zum Thema was eine gute Therapeutin ausmacht; im Interview mit Tony Rousmaniere, zeigt er die Unterschiede zwischen den Besten, und dem Resten von uns auf.

Pourquoi la plupart des thérapeutes sont simplement moyen (et comment nous pouvons nous améliorer)
Résumé

Scott Miller est un psychologue américain contemporain et co-fondateur du Centre international pour l'excellence clinique et l'Institut pour l'étude du changement thérapeutique. Il a coécrit (avec Barry Duncan) *Le Client héroïque : un moyen révolutionnaire pour améliorer l'efficacité par une thérapie dirigée par le client avec des informations-résultats.* Il est aussi un chercheur expert sur ce qui fait un bon thérapeute ; ici, dans un entretien avec Tony Rousmanière, il décrit la différence entre les meilleurs et nous-autres.

1 This interview is published complete and intact with the kind permission of Victor Yalom, Ph.D., CEO &Founder, www.psychotherapy.net. This – and similar articles and interviews – can be accessed on: www.psychotherapy.net/articles-and-interviews

2 Scott Miller: The Road to Mastery: A clip from the 2012 Psychotherapy Networker Symposium: www.youtube.com/watch?v=UUpYfskTTCI

International Journal of Psychotherapy: 2014, Vol. 18, No. 2, pp. 39-49: ISSN 1356-9082
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Почему большинство терапевтов являются средними терапевтами (и как мы можем улучшить ситуацию)

Резюме

Скотт Миллер – современный американский психолог и соучредитель Международного Центра качества медицинской помощи и Института исследований изменений вследствие психотерапии. Он является соавтором статьи «Героический клиент: революционный способ повысить эффективность через использование клиент-направленной терапии, в которой терапевт имеет обратную связь о результате своей деятельности *(Client-Directed, Outcome-Informed therapy* » (вместе с Барри Дунканом). Скотт Миллер также является высококвалифицированным исследователем факторов, создающих хорошего терапевта. В данном интервью с Tony Rousmaniere он анализирует, чем отличаются лучшие терапевты от всех остальных.

*

Escape from Babel

TR: Many people know you as a Common Factors researcher, but recently you've transitioned away from that. Could you explain both what Common Factors is and your transition away from it?

SM: Sure. As old-fashioned as it sounds, I'm interested in the truth – what it is that really matters in the effectiveness of treatment. Early on in my career, I learned and promoted and helped develop a very specific model of treatment, solution-focused therapy.[3] We had some researchers come in near the end of my tenure at the Family Therapy Center in Milwaukee who found that, while what we were doing was effective, it wasn't any more effective than anything else. Now, for somebody who had been running around claiming that doing solution-focused work would make you more effective in a shorter period of time, that was a huge shock.

All models are equivalent. Pick one that appeals to you and your client.

It was at that point that I started to cast about looking for an alternate explanation for the findings, which concluded that virtually everything clinicians did, however it was named, seemed to work despite the differences. That led back to the Common Factors – the theory that there are components shared by the various psychotherapy methodologies and that those shared components account more for positive therapy outcomes than any components that are unique to an approach. It was something that one of my college professors, Mike Lambert,[4] had talked about, but that I had dismissed as not very sexy or interesting. I thought, how could that possibly be true?

It was at that time that I ran into a couple of people that I worked with for some time, Mark Hubble and Barry Duncan[5], and we had written several books about this. If you read *Escape from Babel,* which we co-authored, the argument wasn't that Common Factors were a way of doing therapy, but rather a frame for people—therapists speaking different languages – to share and meet with each other. They were a common ground.

But by 1999, it was very clear to me that Common Factors were being turned into a model by folks, including members of our own team, and viewed as a way to do therapy. But you can't do a Common Factors model of therapy – it's illogical. The Common Factors are based on all models. This caused a large amount of consternation and difficulty, numerous

3 Solution Focused Therapy: www.psychotherapy.net/learning-centers/approach/solution-focused
4 Mike Lambert: www.psychotherapy.net/interview/preventing-treatment-failures-lambert
5 Barry Duncan: www.psychotherapy.net/article/successful-psychotherapists

discussions, and eventually I suggested to the team that the way therapists work didn't make much of a difference.

What was critical was whether it worked with a particular client and a particular therapist at a particular time. Mike Lambert was already moving in this direction and said, *"Let's just measure them. Let's find out. Who cares what model you use? Let's make sure that the client is engaged by it and that it's helping them."* So we began measuring, and what became clear very quickly was that some therapists were better at it than others.

So, since about 2004, Mark Hubble and others at the International Centre for Clinical Excellence (ICCE)[6] have been researching the practice patterns of top performing therapists. It's not that I don't believe, and in fact know, that the Common Factors are what accounts for effective psychotherapy. It's just that an explanation is not the same as a strategy for effecting change. And the Common Factors can never be used as such. All models are equivalent. Pick one that appeals to you and your client.

What I say is, pick one of the 400 that appeals to you and then measure and see: Does your client like it, too? If not, then it's time for you to change, not your client.

TR: So Common Factors are a way of studying the effects of psychotherapy, but not a way of actually implementing it.

SM: Well, by definition, you can't do a Common Factors model because then it's a specific factor. I'm not saying the Common Factors don't matter – what I'm saying is that they are a therapeutic dead end. They will not help you do therapy. You still have to have a method for doing the therapy, and the Common Factors are not a method. Why? All treatment approaches return equal efficacy when the data is aggregated and methods compared in a randomized controlled trial. So you still need some kind of way to operationalize the Common Factors.

Since we have 400 or so different models of therapy, why invent a new one? It seems to be because in our field, each person has to have it their own way. The promise of a new model is a siren song in our profession that we have a hard time not turning our ship towards. What I say is, pick one of the 400 that appeals to you and then measure and see: Does your client like it, too? If not, then it's time for you to change, not your client.

TR: You have an article out in *Psychotherapy* where you mentioned three keys for therapists to improve their work. Your major focus now seems to be how therapists improve their work with each client. Can you describe those three keys?

SM: The first one is knowing your baseline. You can't get any better at an activity until you actually know how good you are at it now. We therapists think we know, but it turns out that data indicates that we generally, as a group, inflate our effectiveness by as much as 65%. So you really have to know just how effective you are in the aggregate. That means you're going to have to use some kind of outcome tool to measure the effectiveness of your work with clients over time. The second step is to get deliberate feedback. So once you know how effective you are, then it's time to get some coaching, get some feedback, and you can do that in two ways. Number one, you can use the very same measures that you used to determine your effectiveness to get feedback from your clients on a case-by-case basis. Meaning that you can actually see when you're helping and when you're not, and use that to alter the course of the services provided to that individual client.

The second kind of feedback to get is from somebody whose work you admire, who has a slightly broader skill base than you do, and have them look at your work and comment specifically about those particular cases where your work falls short. In other words, you

We generally, as a group, inflate our effectiveness by as much as 65%.

6 International Center for Clinical Excellence (ICCE) - www.centerforclinicalexcellence.com

begin to look for patterns in your data about when it is you're not particularly helpful to people, and seek out somebody who can provide you with coaching. It's like in golf, once you know what your handicap is you can hire a coach who can look at your game and make fine tweaks. It's not about revamping your whole style, or about learning an entirely new method of treatment, but pushing your skills and abilities to the next level of performance.

The third piece is deliberate practice. The key word in that expression is "deliberate." All of us practice. We go to work. But it turns out the number of hours spent on a job is not a good predictor. In fact, it's a poor predictor of treatment effectiveness. So what you have to do is identify the edge of your current realm of reliable performance. In other words, where's the next spot where you don't do your work quite as well? And then develop a plan, acquire the skills, practice those skills and then put them into place. Then measure again to see, have you made any improvement?

I can't take credit for coming up with these three steps. We've simply borrowed them lock, stock, and barrel from the performance literature, and in particular, Anders Ericsson's work, which has been applied in fields like the training of pilots, chess masters, computer programmers, surgeons, etc. If we have any sort of claim to fame, it's that we've begun applying these to psychotherapy for the first time.

TR: One of my first reactions to this is, aren't some people just born better therapists?

SM: Well Ericsson notes that the search for genetic factors responsible for the performance of eminent individuals has been surprisingly unsuccessful. In sports we often think, "Oh, there must be some genetic component involved here," or "he just has the gift of music." But it turns out that virtually everyone that researchers looked at where the "gift" is implied, even with Mozart—he had been playing the piano for 17 years before he wrote anything that was unique, which happened at about age 21. He'd been playing since he was 4. His father had been doing music scales with him since he was in the crib. So once you remove the practice component, you just don't find any evidence for genetic factors – with very few exceptions.

Somebody comes in and says, "I'm going to commit suicide." And we respond with, "Do you have a plan? Have you ever attempted this before?" Blah, blah, blah. That's decontextualized knowledge. You could ask those questions to a stick.

For example, in boxing it appears that people with a slightly longer reach have a slight advantage. But we also know that if baseball pitchers don't start pitching at a particular age, their arms will not make the adjustment required to throw the ball as fast and accurately as professional pitchers do.

There was another study that looked at social skills. You often will hear, in addition to the genetic claims, that, *"Good therapists just have great social skills."* Well, they've measured that. It turns out not to be the case, and the reason is that these kinds of ideas are too high or general a level of abstraction. The real difference between the best and the rest is that they possess more deep, domain-specific knowledge. They have a highly contextualized knowledge base that is much thicker than average performers, and much more accessible to them and responsive to contextual clues.

Deep Contextual Knowledge

TR: Could you give a specific example of what a deep contextual knowledge would look like in a therapy room?

SM: Well the classic one – and I say it to make fun of it – is suicide contracting. Or the suicide prevention interview. Somebody comes in and says, *"I'm going to commit suicide."* And we respond with, *"Do you have a plan? Have you ever attempted this before?"* Blah, blah,

blah. That's decontextualized knowledge. You could ask those questions to a stick.

What a top performer does is ask those questions very differently, nuanced by the client's presentation, in ways that the rest of us can't see. Because of their more complex and well-organized knowledge, they can actually see patterns in what clients present that the rest of us would miss and respond to in a much more generic fashion. Is this making sense?

TR: Absolutely.

SM: So the real question is how to help clinicians develop that highly contextualized knowledge. Because once you have it, not only can you retrieve that knowledge at the appropriate moment, but it turns out you can make unique combinations and use them in novel ways that would never occur to the rest of us, or would only occur to the rest of us by chance.

TR: This also doesn't suggest that treatment manuals are necessarily the best way to train therapists.

SM: We know that following a treatment manual doesn't result in better outcomes and it doesn't decrease variability among clinicians using the same manual. So you still get a spread of outcomes, even when everybody is doing the same treatment.

At the same time, I think it's critical that therapists learn a way of working, and, in the beginning at least, they hew to that approach. Why? Well, if you begin to introduce variation in your performance early on, you will not have the same ability to extend your performance in the future.

Let me give you an example. The first time I had a guitar lesson, I was taking classical guitar with this really interesting teacher. We spent the entire first lesson on how he wanted me to hold the neck of the guitar with my left hand—and I'm right handed. He said, *"If you try to vary your hand grip from the outset, you'll never have the same reach and ability to vary reliably when you need to in the future. So start with a common foundation, and then when we need to introduce variations later, we will."* My sense is that therapists instead begin in a highly complex, nuanced way and introduce variations into their style randomly and without much thought.

TR: So it would be better to begin with a frame or structure that provides a stable base, and then develop the deep contextualized knowledge later on.

SM: And to vary your work in ways that allow you to measure the impact of your variation against what you usually do. This is the key. Otherwise, what you have is a bag of tricks. You can do them all, but there's no cohesiveness to it, and you can't explain why you vary at certain times rather than others.

The difference between the best and the rest is what they do before they meet a client and after they've met them, not what they're doing when they're with them.

TR: Starting with a manual isn't necessarily a bad idea then.

SM: Absolutely not. In fact, I would suggest grabbing a manual and going to a place where they are teaching a specific approach that will allow you to practice and also watch others in a two-way mirror. Once you have that foundation down, you can introduce your own variations.

TR: I hear therapists say, *"I have 20 years experience," or "I have 30 years experience."* Does this research find that experience, itself, makes someone better?

SM: No, it doesn't. We know that not only in therapy, but in a variety of activities. If you think about it, you'll understand why. While you're doing your work, you don't have time enough to correct your mistakes thoughtfully. So what we found, which I think is quite shocking, is that the difference between the best and the rest is what they do before they meet a client and after they've met them, not what they're doing when they're with them. Let me give you an example from a field that is similar—figure skating. If you watch a championship

figure skater perform a gold medal winning performance, you can describe what they did, but it won't tell you how to do it yourself. Do you follow me?

TR: Yeah.

SM: In order to be able to accomplish that performance, that figure skater must do something before they go on the ice, and after they leave the ice. It's that time that leads to superior performance. You can go out and try to turn triple axels during the performances as much as you want. That experience will not make you better. You have to plan, practice, perform, and then reflect. Most of us don't see all of the effort that goes into that great performance. We just appreciate how good it is.

TR: But one of the tricky differences is that we're trying to help each client. And if we're practicing new skills, invariably we're going to make mistakes. And that's emotionally harder because you're making a mistake with a real person sitting across from you.

SM: Well, number one, we're all already making these mistakes. And the ones that I'm referring to are generally small and not fatal. So your performance doesn't improve by isolating gross mistakes, or gross skills. Your performance improves when your usual skills begin to break down – meaning they don't deliver—and remembering those, thinking about them after the session, and making a plan for what to do instead. That's where improvement takes place.

The best performers spend significantly more time reading books and articles ... and reviewing basic therapeutic texts.

When I hear people mention this kind of objection, I think they're thinking that the errors are far grosser than what I'm talking about. Once therapists assess their baseline, most are going to find out – to their, perhaps, surprise – that they're average in terms of their outcome, or slightly less than average. So if we're average, then it's not about bringing your game up to the average level. It's about extending it to the next. That requires a focus on small process errors.

Let me give you another example. We have a pianist come and perform at one of our conferences. She is eight years old and she is really unbelievably able as a concert pianist. She plays a very difficult piece. I ask her if she made any mistakes. She says, *"Of course, I made a lot."* I tell her I didn't hear any, to which she says, *"Well, that's because you're no good at this."* I then say, *"What do you mean? And what do you do about your mistakes?"*

She says, *"Look. I made lots of mistakes, but you cannot get better at playing the piano while you're performing."* This is an 8-year-old. I say, *"So what do you do?"* She says, *"Well, I hear these small errors. I remember them. My coach in the audience remembers them, and then that's what I isolate for periods of practice between performances."*

Most of Us Are Average

TR: How many therapists really practice between sessions? I mean, that's pretty rare, isn't it?

SM: Most of us are average.

TR: Right.

SM: And 50% of us are below average, right? So very few people do it, and this is the real mystery of expertise and excellence. Why do some go this extra mile? There's no financial pay-off. I think this will change in the future, but at the present time, you don't get paid one dime more if you're average, crappy, or really good. The fees are set by the service provided.

We don't know about workshops. I'm cynical about them, simply because they're not set up in a way that respects any principles of the last 30 years of research on human learning.

TR: That is a great problem with our field and I hope that does change in the future.

SM: I think that we're seeing movement in that direction. I think

that our field will become like other fields, where outcome of the process is what leads to payment, rather than the delivery of it.

TR: So, back to practicing. Therapists read books and go to workshops, but that's kind of passive learning. What are your thoughts about that?

SM: That's a component of practicing. A graduate student that I've been working with, Darryl Chow, who just finished his PhD at University of Perth in Australia, did his dissertation on this topic and found that the best performers spend significantly more time reading books and articles. We also know that the best performers spend more time reviewing basic therapeutic texts.

Therapists are often in search of the variation from their performance that will allow them to reach an individual client they're struggling with. Top performers not only do that, but they're also constantly going back to basics to make sure they've provided those. They spend time reading basic books that may be hugely boring but are nonetheless really helpful. Gerard Eagin's *The Skilled Helper*, Corydon Hammond's book on therapeutic communication[7] — these basic texts that remind us of things that we often forget in the flurry of cases we see every week.

TR: So reading counts. What about workshops?

SM: We don't know about workshops. I'm cynical about them, simply because they're not set up in a way that respects any principles of the last 30 years of research on human learning. Six hours, chosen by the person who needs the continuing education, and there's no testing of skills, acquisition of skills, no awareness of particular deficits in practice. Greg Neimeyer has done a fair bit of research on this and he finds no evidence that our current CE standards lead to improved performance. None.

TR: There's a psychotherapy instructor I know, Jon Frederickson, who has his students go through psychotherapy drills, kind of like role-playing drills in a circle. Would that count as practice?

SM: It depends, but I like the sound of it. Not a scrimmage, where you do a whole game, but rather drilling people in very specific small skill sets again and again. That aligns with the principles of Ericsson's researchers.

If you're an experienced professional, your motivation for going to a CE event can be really varied. I know for me, I'm often just grateful to have a day off and hang out with friends. The particular content of the workshop, I'm ashamed to admit, is less important. The incentives are just all wrong.

TR: It goes back to your motivation question.

SM: I don't think our field incentivizes that kind of stuff. In fact, you can be punished.

TR: Well, one incentive I discovered myself in my own private practice was my drop-out rate. That motivated me to get further training. Maybe other therapists don't have the same problem I had, but I know that was a powerful motivation.

SM: Drop-out can be both a good and a bad thing. For example, our current system incentivizes therapists to have a butt in the seat every available, billable hour. What that means is that therapists may be incentivized—we have some data about this, too—to keep clients, whether they are changing or not. That's what I mean when I say that the incentives are all screwed up. There are, every once in a while, motivated people like yourself who say, "Wait a second. There has to be something beyond this." But that requires a degree of reflection that may be difficult for most of us, especially if we are well defended. For these

7 Corydon Hammond, Dean H. Hepworth, & Vern B. Smith (2002). Improving Therapeutic Communication P: A Guide for Developing Effective Techniques. New York: Wiley & Sons.

folks, people drop out because they are in denial about their own problems, not because of anything they, themselves, might be doing.

You put those things together and it can be a fatal combination. We need to take a step back as payers for services and as consumers of services and think about the incentives in our current system. I know this sounds terribly economic, but I think it's important for our field.

TR: That sounds sensible to me. What about watching psychotherapy videos[8] by psychotherapy experts like the ones psychotherapy.net produces. Would that count as practice?

SM: Yes it would. Especially in the beginning, when you have identified a particular area or weakness in your skill set that you may need some help with. In essence, you're spending more time swimming in it while reflecting, which is the key part.

TR: Do you have other examples of deliberate practice that you've heard of therapists engaging in?

The key to this is really starting early and investing a little bit at a time. It's sort of like how you're advised to save for your retirement. Not in the last five years.

SM: Well there's the 'stop-start; strategies that Darryl Chow has been talking about. And Chris Hall is doing a study at UNC that we're involved with, where therapists will watch short segments of a video and then they have to respond in the moment in a way that is maximally empathic, collaborative, and non-distancing. So they're training therapists to develop a certain degree of proficiency with fairly straightforward clients.

Then you begin to vary the emotional context, or the physical context, in which the service is delivered. So now the client's not just saying, *"Hey, I feel sad."* They're threatening to drop out or to commit suicide. More difficult and challenging things. And then simply spending time outside of the office planning and discussing individual particular cases with peers or consultants is another strategy.

In Darryl Chow's research,[9] which I think is the most exciting stuff, he found that within the first eight years of practice, therapists with the best outcomes spend approximately seven times more hours than the bottom two-thirds of clinicians engaged in these kinds of activities. Seven times.

TR: Wow.

SM: The good news is, now that we know this, we can start this process earlier. The bad news is, if you've been at this for awhile, it becomes impossible to catch up with the best. We just age out. We can't do it. The key to this is really starting early and investing a little bit at a time. It's sort of like how you're advised to save for your retirement. Not in the last five years. Not in the first five years, but a little bit every year.

TR: One advantage that great athletes have is that their coaches gets to determine day by day what moves or what performances they're going to practice. I run a training program here at University of Alaska, Fairbanks, at the University Center for Student Health and Counseling, and I don't get to pick what clients come in day to day. It could be anxiety, depression, any number of different things, so I'll do a training on, let's say, working with anxiety, but the client that comes in will have depression. So what do you do about that?

SM: Well, in essence, we're violating John Wooden's primary rule, which is, we are allowing students to scrimmage before they drill. And I have to tell you, all students want to scrimmage, but what you need to do more of, before and during, is drilling. The kind of

8 Psychotherapy videos: e.g. www.psychotherapy.net/videos

9 Scott D. Miller, Mark A. Hubble, Daryl L. Chow & Jason A. Seidel (2013). The Outcome of Psychotherapy: Yesterday, Today and Tomorrow. Psychotherapy, Vol. 50, No. 1, pp. 88-97. Available here: www.academia.edu/3100690/The_Outcome_of_Psychotherapy_Yesterday_

drilling that I think your colleague was talking about. Or you go back to, *"Here's how we hold the guitar."* And we play very simple songs and then we begin varying the drill with greater degrees of complexity once easier tasks are managed.

TR: So you'd recommend a longer period of training and practice and drills before seeing clients.

SM: I'd want to see that kind of mastery. Let me give you an example. Do you want the pilot to be proficient at flying in fair weather, as demonstrated on the simulator, before they fly a plane?

TR: Yes.

SM: You want them to be prepared for all the complications: *"Wait a minute, it's raining," "Wait a minute, you've got problems with your rudder."* These are complex skills and, yes, we can teach people to manage them as one-offs, but then they never integrate it into a coherent package that makes it easier to retrieve from memory later on when they need that skill. If it's viewed as a one-off—*"With the anxiety client, I did this"* – it's not integrated into an organized structure for retrieval later on.

TR: So on a therapist's resume, you'd want to see not just hours of direct service provided, but also hours spent practicing and learning.

SM: Or, better yet, somebody who has measured results, like yourself. All I need is an average pilot. I don't need the best pilot in the world, because most of the time there's not huge challenges. If you can document your results, and if you're checking in with me, we're going to catch most of the errors anyway. And then I want a therapist who has a professional development plan, that's working on the aggregation of small improvements over a long period of time.

Instead of becoming fully connected to our performance, we are constantly looking for the trick that will make us great.

TR: So for tracking results, I know you recommend quantitative outcome measures, like the Outcome Rating Scale or the Outcome Questionnaire. But I have found that there are certain clients that quantitative measures just don't seem valid for. It's not a large percentage of clients, but there are some that underreport problems at first. So it can look like they're deteriorating even while they're improving. Can you recommend any kind of qualitative methods or other methods of trying to accurately assess outcome in addition to those measures?

SM: I don't buy it. Personally, I just don't see that stuff and I would offer a very different explanation for it. Let me give you an example.

We know that each time there is a deterioration in scores, the probability of client drop-out goes up, whether or not the therapist thinks that it's a good sign that the client is "getting in touch with reality and finally admitting their issues," or had inflated how they really were doing for the first visit. So the key task here is not to say, "There must be another measure," but to figure out what skills are required for me to get a higher score.

TR: That's a new perspective. To look at what I can change about my performance, rather than a new measure to assess it.

SM: Now you see why I think our field is forever chasing its tail. Because instead of becoming fully connected to our performance, we are constantly looking for the trick that will make us great.

It's like a singer looking for the song that will make them famous rather than learning how to sing. We're forever going to workshops, and the level of the workshops are often so basic even when they've claimed to be advanced. The truth is, you can't do an advanced workshop on psychotherapy for 100 people. You can't do it. The content is too abstract and too general. You need to see a clinician's performance and fine-tune it. So therapists go

around and around, constantly picking up these techniques that they use in an unreliable fashion, and their outcomes don't improve, but their confidence does.

TR: So instead of picking up a new modality every year, dig into the one you know, preferably with a real expert, and get individualized or maybe small group training and practice.

SM: I think that once you've achieved a level of proficiency, the only hope for improvement is to get feedback on your specific deficits. And yours will be different from mine.

TR: It sounds like you'd definitely be a fan of videotaping sessions and reviewing them and that kind of thing.

SM: Not alone - with an expert eye reviewing small segments. Otherwise the flood of information from video will have you second-guessing yourself, which can actually interrupt the way you work in an unhelpful way.

TR: What about live supervision?

SM: I'm not averse to it, but I think it's a little bit like a GPS - it can correct your moves in the moment, but you become GPS-dependent and you don't learn the territory. What's required in learning is reflection. If you don't reflect, you can't learn. As my uncle used to say, "You got to study that thang."

I actually had great opportunities with live supervision when I was at the Family Therapy Center and got corrected in the moment by two really masterful clinicians. But I also think that what really made a difference was sitting behind a mirror, without any financial worries, watching endless hours of psychotherapy being done, and then talking about it afterwards. *"This was said. What could you have said? How come we said this? What do you need to do?"* It was a heavenly experience and as a result, I came away with a very highly nuanced and contextualized way of delivering that particular model.

And today, when I'm doing my Scott Miller way of working and I notice that a particular client wasn't engaged or interested at a particular moment, I think, *"What could I have said differently?"* It's at that small micro level that improved outcome is likely to be found. As opposed to just gross generic level.

People go to workshops and say, *"I've had some traumatized clients. Maybe I'll learn that EMDR thing."*

"Really?" I think. *"Do you know how effective you are in working with these clients already?" "No, I don't." "What makes you think you need to do EMDR?" "Well, it just seems so interesting."*

And I think, *"Oh, you're doomed."* Not that there's anything wrong with EMDR, but I have to tell you, I watched Francine Shapiro do it and it looks a lot different than some other people I've seen doing it.

TR: So the problem there is switching modalities rather than getting a lot better at the one you're currently using.

SM: It's looking for a trick rather than thinking through, what else could I have said? What else could I have done that I already know how to do? Or getting a little bit of tweaking from a trusted mentor.

TR: I know you present this information all over the world. Do you find therapists are open and receptive to these ideas?

SM: Yes. I think that there are some very real barriers that we need to address, but yes, I do.

TR: This has been a really fascinating conversation. Thank you for making the time.

SM: I like this stuff. I'm fascinated by it and I'm very hopeful about the direction we're going research-wise, so thank you for giving me the opportunity.

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Pharmacotherapy vs. Psychotherapy in the management of depression and anxiety disorders

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Submitted 21-Nov-2013: peer-reviewed twice Feb & Mar 2014; Revised and resubmitted 23-Mar-2014; Accepted.

Abstract

Background: Evidence-based practice advocates decisions based on evidence. While pharmacotherapy had been a mainstay in the management of depression and anxiety disorders in the past, psychological interventions (like counselling and psychotherapy) are gaining in popularity and approval from public and healthcare professionals alike. The evidence-bases for comparing these two very different treatment modalities are often complex and sometimes contradictory.

Aims: This article aims to explore the evidence-based behind these two treatment modalities with respect to the treatment of depression and anxiety disorders.

Method and outcome: A literature review was carried out in Medline searching only systematic reviews and meta-analyses, comparing psychotherapy and pharmacotherapy for depression and anxiety disorders. Six systematic reviews on depression and four on anxiety disorders were found. There were also several other pertinent articles that were consulted.

Conclusion: The current evidence base suggests that pharmacotherapy and psychotherapy, especially CBT, may be equally effective in the treatment of depression and in most anxiety disorders, although any firm or definitive evidence-base would require further direct comparative studies. However, this presumes one is comparing like-with-like, which is not necessarily the case.

Keywords: Pharmacotherapy, Psychotherapy, Depression, Anxiety Disorder, Evidence-based

Pharmakotherapie versus Psychotherapie in der Behandlung von Depressionen und Angststörungen
Zusammenfassung

Hintergrund: Evidenzbasierte Praxis Befürworter treffen Entscheide anhand auf Beweisen. War in der Vergangenheit die Pharmakotherapie eine tragende Säule in der Behandlung von Depressionen und Angststörungen, gewannen die psychologischen Interventionen (wie Beratung und Psychotherapie) an Popularität und Anerkennung in gleichem Masse bei öffentlichen und medizinischen Fachkräften. Die Grundlagen für Evidenz basierende Vergleiche, dieser zwei sehr unterschiedliche Behandlungsmodalitäten, sind oft komplex

International Journal of Psychotherapy: 2014, Vol. 18, No. 2, pp. 50-61: ISSN 1356-9082
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und manchmal widersprüchlicher Art.

Ziele: Dieser Artikel erkundet die Evidenzbasierung der Behandlung von Depressionen und Angststörungen, dieser beiden Behandlungsmodalitäten.

Methode und Ergebnisse: Eine Literaturrecherche wurde in Medline Suche nach systematischen Reviews und Meta-Analysen, Vergleichen Psychotherapie und Pharmakotherapie bei Depressionen und Angststörungen, durchgeführt. Gefunden wurden sechs systematischen Reviews für Depressionen, sowie vier für Angststörungen. Mehrere andere relevante Artikel wurden konsultiert.

Fazit: Die aktuelle Beweisgrundlage zeigt, dass die Pharmakotherapie und die Psychotherapie, vor allem CBT, ebenso wirksam in der Behandlung von Depressionen und Angststörungen sind. Jedoch, um weitere verbindliche oder endgültige Beweisgrundlagen zu bekommen sind weitere direkte Vergleichsstudien erforderlich. Voraussetzung dafür ist, dass Gleiches mit Gleichem verglichen wird, was nicht immer der Fall ist.

Schlüsselwörter: Pharmakotherapie , Psychotherapie , Depression, Angststörung , Evidenzbasiert

Pharmacothérapie vs. Psychothérapie dans la gestion de la dépression et des troubles anxieux

Résumé

La trame de fond : Une pratique basée sur des preuves prône des décisions fondées sur des preuves. Alors que, par le passé, la pharmacothérapie a été la valeur sure dans la gestion de la dépression et des troubles anxieux, des interventions psychologiques (tel que le conseil et la psychothérapie) ont gagné en popularité et approbation, tant du publique que des professionnels de santé. Les bases de preuves servant de fondement pour comparer ces deux modalités de traitement très différentes sont souvent complexes et parfois contradictoires.

Objectif : Cet article vise à explorer les fondements de preuves derrière ces deux modalités de traitement par rapport à la façon de traiter la dépression et les troubles anxieux.

Méthode et résultat : Une étude de publications sur le sujet a été menée par Medline en recherchant uniquement les revues systématiques et les méta-analyses, comparant la psychothérapie et la pharmacothérapie pour la dépression et les troubles anxieux. Six revues systématiques sur la dépression et quatre sur les troubles anxieux ont été trouvées. Il y a eu aussi plusieurs autres articles pertinents qui ont été consultés.

Conclusion : La base actuelle de preuves suggère que la pharmacothérapie et la psychothérapie, surtout la thérapie cognitive-comportementaliste, peuvent être tout aussi efficace l'une que l'autre dans le traitement de la dépression et dans la plupart des troubles anxieux, bien que toute base de preuves ferme et définitive requerrait davantage d'études comparatives directes. Cependant, ceci présupposerait qu'on compare deux choses identiques, ce qui n'est pas nécessairement le cas.

Mots clés : Pharmacothérapie, Psychothérapie, Dépression, Trouble anxieux, Base de preuves

Фармакотерапия vs. психотерапия в лечении депрессии и тревожных расстройств

Резюме

История вопроса: Практика, основанная на эмпирических исследованиях, предлагает решения, основанные на фактах. В то время, как в прошлом фармакотерапия являлась

основным способом лечения депрессий и тревожных расстройств, сейчас все большую популярность и одобрение, как среди населения, так и в среде профессионалов из области здравоохранения, приобретают психологические интервенции (консультирование и психотерапия). Основанное на фактических данных сравнение этих двух очень разных модальностей лечения, часто является сложным, а иногда и противоречивым.

Цели: Целью данной статьи является исследование данных о результатах применения этих двух модальностей в лечении депрессий и тревожных расстройств.

Метод и результат: Для сравнения фармакотерапии и психотерапии депрессий и тревожных расстройств использовались только систематические обзоры и мета-анализ, приведенные в медицинской базе данных «Медлайн». Были обнаружены шесть систематических обзоров лечения депрессии и 4 обзора лечения тревожных расстройств. Были также проанализированы данные некоторых других статей по указанной тематике.

Выводы: Данные, полученные на настоящий момент, дают возможность предположить, что фармакотерапия и психотерапия, особенно когнитивно-бихевиоральная терапия (CBT), могут быть в равной степени эффективны при лечении депрессий и большинства тревожных расстройств. Для твердого и окончательного вывода мог бы потребоваться дальнейший сравнительный анализ, однако в этом нет необходимости, так как это означало бы сравнение подобного с подобным.

Ключевые слова: фармакотерапия, психотерапия, депрессия, тревожные расстройства, основанные на фактах данные.

Introduction

Evidence-based practice advocates underpinning any treatment decisions by rigorous scientific research evidence; and the practice of mental health is no exception. Despite various debates about what constitutes 'good' evidence (Slade & Priebe, 2001), it is generally regarded that clinical decisions should be based on reasonably clear evidence. In terms of the hierarchy of evidence, systematic reviews and meta-analyses of randomized controlled trials (RCTs) are considered to be the strongest forms of evidence, although some researchers (Slade & Priebe, 2001) argue that there is a bias here and a neglect of evidence from the fields of the social and natural sciences, especially in respect to mental health treatments. Clinicians often tend to choose medication (pharmacotherapy) over psychological therapy for a variety of reasons; including the general unavailability of psychological therapy. However, this approach needs closer scrutiny. This article explores and discusses the evidence-base for psychotherapy (PsT) and pharmacotherapy (PhT) for the management of depression and anxiety disorders.

At this point, one also has to differentiate between what is classified as 'severe' depression or 'mild to moderate' depression, and also between what is considered as an emergency situation, 'acute' depression, medium-term depression, and 'chronic' depression. For example, in the emergency treatment of depression, only a small range of treatments are available and some form of pharmacological treatment is probably necessary, being reasonably efficacious and with a fairly rapid response; in some of these emergency cases, electro-convulsive therapy may even be indicated (Porter & Ferrier, 1999; Anderson, IM; Baldwin, RC; Cowen, PJ; Howard, L; Lewis, G; Matthews K., 2008). But it is also generally recognised that some form of psychotherapy should also be used to back up these emergency (psycho-pharmacological) responses, which is often the case.

In cases of (non-emergency) severe depression, given its complexity and the wide range

of aetiologies, there are strong indications that several non-pharmacological aspects of management and treatment strategies should be considered much earlier (Porter, Linsley & Ferrier, 2001); and also that major depression is probably best treated with a combination of psychotherapy and pharmacotherapy, rather than with psychotherapy or pharmacotherapy alone (Thase, *et al.,* 1997).

This is also indicated in the recommended treatment of 'mild to moderate depression', where there is a hierarchy of strategies, a "stepped care" system, suggested by the NICE Guidelines for Depression (2009), ranging from guided self-help to brief counselling, then a combination of medication and longer-term counselling or psychotherapy, to a referral (out of primary care) to clinical psychology and/or psychiatry.

It can further be stated– generally – that the sooner the onset of treatment after diagnosis, the better the prognosis; that, in the instance of recurrent depression, the prognosis is improved by the combined therapy option (Thase, *et al.*, 1997); and that the age, social situation, relationship with the therapist and motivation of the patient, etc. are also all significant factors (Wampold, 2001; Imel, *et al.*, 2008). Finally, we can read: *"the results of psychotherapy tend to last longer and be less likely to require additional treatment courses than psychopharmacological treatments. For example, in the treatment of depression and anxiety disorders, psychotherapy clients/patients acquire a variety of skills that are used after the treatment termination and generally may continue to improve after the termination of treatment (Hollon, Stewart, & Strunk, 2006; Shedler, 2010)"* (APA, 2012). ……..

Personally, as a pharmacist, do I have an inherent bias favouring pharmacotherapy for mental health treatment? As a Buddhist and a regular meditator, do I favour mindfulness practice and forms of compassionate response, as in psychotherapy? I do not consider having any conscious preconceived bias if, however, these two competing views are within me unconsciously, I hope they will complement each other to give an objective and evidence based view.

Psychotherapy, as defined by Strupp (Strupp, 1978), is *"An interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behaviour which have proved troublesome to the person seeking help from a trained professional."* Treatment of any physical or mental illness using medicine is known as 'pharmacotherapy'. Leaving the placebo effect aside, it is the drugs that produce a variety of effects, usually aimed at a reduction in the symptoms of depression or anxiety, via modulation of neurotransmitters (serotonin, noradrenaline etc.) or neuro-receptor activity, and usually during the actual course of the pharmacotherapy, whereas psychotherapy produces effects that can have a huge variation in the person's general qualities: like social efficacy, well-being, resilience, etc. and these effects can last long after the therapy has ended.

There exist many different forms (or modalities) of psychotherapy, including cognitive behavioural therapy (CBT) in various formats, interpersonal psychotherapy (IPT), psychodynamic psychotherapy, problem-solving (solution-focussed) therapy, and various non-directive, supportive counselling type psychotherapies. Similarly, pharmacotherapy for the treatment of depression and anxiety disorders includes: tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), serotonin and noradrenaline reuptake inhibitors (SNRIs), and noradrenergic and specific serotonergic antidepressants (NaSSA) amongst others. SSRIs are currently considered the 'first-line' in terms of drug treatments for depression and anxiety disorders; whereas CBT seems to have a stronger evidence-base in terms of psychotherapy, though some argue that it is more suited to the 'form' of 'evidence' generally required and that counselling is equally effective (King, *et al.*, 2013).

Debate in the literature usually focuses on efficacy of pharmacotherapy compared to psychotherapy and combinations of pharmacotherapy plus psychotherapy compared to either treatment alone in the treatment of depression and anxiety disorder (e.g. Thase, *et al.,* 1997).

Evidence-Base

In looking at the individual disorders and comparing these two treatment modalities and exploring the evidence-base, one finds the following:

Depression

A brief summary of various systematic reviews and meta-analysis comparing Pharmacotherapy (PhT) and Psychotherapy (PsT) in the management of depression is outlined in the Table 1 below.

In the most recent (2013) meta-analysis (Cuijpers, *et al.,* 2013) comparing psychotherapy and pharmacotherapy in treating depressive and anxiety disorders, they found the overall mean effect size of 0.02 in favour of psychotherapy, but this is not significantly different from zero, and is with a moderate to high heterogeneity. However, when possible outliers were removed, a small, non-significant effect size in favour of pharmacotherapy was observed with lower heterogeneity. The authors found that the difference between psychotherapy and antidepressant was therefore small to non-existent for major depression. The study also concluded that pharmacotherapy was more efficacious than psychotherapy in dysthymia, in line with previous studies (Cuijpers, *et al.*, 2010) (Cuijpers, *et al.*, 2008; Imel, *et al.*, 2008).

Table 1: Brief summary of evidence base for depression

Reviews	**Authors' Conclusion**
Cuijpers, *et al.*, 2013	Small (favouring PsT) to no difference in MDD. PhT better in dysthymia.
von Wolff, *et al.*, 2012	PhT+PsT is no better than PhT alone but improved QoL in chronic depression.
Cuijpers, *et al.*. 2010	PhT (especially SSRI) more effective than PsT. PhT+PsT more effective than either treatment alone.
Cuijpers, *et al.*, 2008	SSRIs (but not others) more effective that PsT in MDD. But smaller dropouts in PsT compared to PhT.
Imel, *et al.*, 2008	PhT & PsT both viable options in unipolar depression. PsT may offer prophylactic effect.
Casacalenda, *et al.*, 2002	No significant differences

Keys: MDD = Major Depressive Disorder; PhT = Pharmacolotherapy; PsT = Psychotherapy; QoL=Quality of Life; SSRIs = Selective Serotonin Reuptake Inhibitors.

In their previous meta-analysis (Cuijpers, *et al.*, 2010), psychotherapy was significantly less effective than pharmacotherapy in direct comparisons, especially with SSRIs, but the authors report that this finding was wholly attributable to dysthymic patients. Combined treatments (pharmacotherapy + psychotherapy) were more effective than pharmacotherapy or psychotherapy alone. There were no significant differences found in the drop-out rates.

Cuijpers and colleagues conducted another meta-analysis (Cuijpers, *et al.*, 2008) and found that SSRIs were significantly more effective than psychological treatment in patients with major depressive disorders, while treatments with other antidepressants did not

differ significantly. However, the authors reported a smaller dropout rates in psychological interventions compared with the pharmacological treatments.

In their systematic review and meta-analysis, Von Wolff and colleagues (2012) reported that there was no clear evidence of any benefits in combining pharmacotherapy and psychotherapy, compared to pharmacotherapy alone in the treatment of chronic depression. And there were no differences in acceptance rates and long-term effects between combined treatments, compared to pharmacotherapy alone. But the authors noted small but significant add-on benefits to the quality of life when psychotherapy was added to pharmacotherapy in chronically depressed patients.

Imel and colleagues (2008), in their meta-analysis, indicated that both psychotherapy and medication are viable treatments for depression and that psychotherapy may offer a prophylactic effect, not provided by medication. However the questions remain – how and why?

The review by Casacalenda et al. (2002), on the remission of depression with pharmacotherapy compared to psychotherapy, concluded that there were no significant differences although dropout rates was higher (37.1%) in the drug treatment group than those in psychotherapy (22.2%). However, the antidepressants used in all those included studies were TCAs and MAOIs, which are not now commonly used as a front-line treatment and they are also known to cause more side-effects than newer antidepressant, such as SSRIs.

Current UK treatment guidelines – on depression – (from the National Institute for Health and Clinical Excellence: the official body that approves medications and treatments) (NICE, 2009) recommends CBT (in terms of psychotherapy) and SSRIs (for pharmacotherapy) and also a "stepped-care" model offering a mixture of psychotherapy and/or pharmacotherapy depending on:

- duration of the episode and trajectory of the symptoms
- previous course of the 'illness' and responses to previous treatments
- likelihood of adherence (continuance) and potential adverse effects
- person's preference
- the course and treatment of any chronic physical health problems

However, after considerable pressure from UK professional counselling and psychotherapy associations (like the UKCP, BACP and the BPS), NICE is now about to reconsider the criteria by which they assess the efficacy and effectiveness of psychological therapies, as being significantly different from pharmacological therapies. This may mean the end to the "gold-standard" of RCTs (which require manualised treatment schedules) and which therefore favour CBT over other modalities of psychotherapy.

Anxiety disorders

Craske (Craske, 2013) reported that there is insufficient evidence comparing CBT to medication for generalized anxiety disorder (GAD) to favour one modality over the other. This is reaffirmed by Cuijpers (Cuijpers, *et al.*, 2013) in their meta-analysis where only one randomized controlled trial met their inclusion criteria and even that was of poor quality. Previous meta-analyses by Mitte, *et al.* (2005) suggest that pharmacotherapy and psychotherapy are of equal efficacy in the treatment of GAD. In line with this, the NICE guideline on Anxiety (NICE, 2011) recommends to offer either an individual high-intensity psychological intervention, or a drug treatment [only] when low intensity psychological interventions provide inadequate responses or a marked functional impairment.

In the most recent meta-analysis by Cuijpers and colleagues (Cuijpers, *et al.*, 2013), the differences in effects between psychotherapy and antidepressant medication were small to non-existent for social anxiety disorder (SAD) and for major panic disorder. This study included 7 randomized trials on SAD, and all of the trials were assessed to be of good quality, except one. The authors assessed the quality of the trials based on four criteria: allocation sequence, concealment of allocation to conditions, blinding of assessor, and intention to treat analysis. All but one of the included SAD trials met all four criteria. Similarly, the meta-analysis included 11 studies on panic disorder, but only 3 met all four quality criteria mentioned above, and 3 did not meet any of the criteria. This may also be an indication of the paucity of the research criteria when assessing psychological therapies. Table 2 summarizes systematic reviews and meta-analysis comparing Pharmacotherapy (PhT) and Psychotherapy (PsT) in the management of anxiety and related disorders.

Table 2: Brief summary of evidence base for Anxiety related disorders

Reviews	**Authors' Conclusion**
Craske, 2013	Insufficient evidence to favour PhT over PsT or vice-versa for GAD.
Cuijpers, *et al.*, 2013	
Mitte, *et al.,* 2005	PhT and PsT are equally efficacious for GAD
Cuijpers, *et al.*, 2013	No significant differences between PhT and PsT for SAD and panic disorder.
NICE, 2013	PsT (CT) better than PhT (Phenelzine) for SAD.
Cuijpers, *et al. 2013*	PsT better than PhT for OCD.
Jonas, *et al.*, 2013	PsT more effective than PhT in PTSD.
Stewart & Wrobel, 2009	PhT more effective than PsT in combat-related PTSD.

Key: GAD = Generalized Anxiety Disorder; SAD= Social Anxiety Disorder; PTSD= Post-Traumatic Stress Disorder; OCT = Obsessive Compulsive DIsoder; PhT = Pharmacolotherapy; PsT = Psychotherapy; CT = Cognitive Therapy;

NICE (NICE, 2013) found that cognitive therapy (Clark & Wells. 1995) had the highest probability of recovery from SAD, followed by the use of Phenelzine. Although it found Phenelzine the most cost-effective treatment for SAD 1 year post-treatment; CT was the most cost-effective for 5 years post-treatment. NICE recommended cognitive therapy (CT) as a first-line treatment for SAD, based (purely) on their cost effectiveness analysis.

The most recent systematic review and meta-analysis (Jonas, *et al.*, 2013) of 92 randomized controlled trials on psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD) – which, it must be noted, is not necessarily classed as an anxiety disorder. The study reported that effect sizes were generally large for psychotherapy compared to pharmacotherapy. In terms of improving PTSD symptoms, psychotherapy reduced 28.9 points on Clinician-Administered PTSD Scale (CAPS) compared to a reduction of between 4.9 to 15.5 points with pharmacotherapy. Numbers needed to treat (NNTs) for psychotherapy was ≤ 4 to achieve one loss of PTSD diagnosis. This compared to NNTs of 8 for inducing one remission for paroxetine and venlafaxine, which are the two drugs that the authors found the best evidence for treating PTSD: although we need to be mindful that the loss of PTSD diagnosis is not necessarily the same as someone being in remission. Despite lack of direct evidence (from head-to-head trials) to support psychotherapy as a preferred first step, with medications as an adjunct or a next line treatment, the authors support exposure therapy as a first-line treatment for PTSD because of the magnitude of benefit and strength of evidence they found.

This was contrary to findings from previous meta-analysis (Stewart & Wrobel, 2009), which included 13 pharmacotherapy and 12 psychotherapy studies in combat-related PTSD, which concluded that pharmacotherapy was superior to psychotherapy in reducing PTSD symptoms and depression symptoms. However this finding should be treated with caution, due to its potential for bias in the review, the uncertain quality of the included studies, and the indirect comparison of pharmacotherapy and psychotherapy interventions (Stewart & Wrobel, 2009).

A meta-analysis by Cuijpers, *et al.* (2013) concluded that psychotherapy was more efficacious than pharmacotherapy for Obsessive-Compulsive Disorder (OCD). The meta-analysis included a total of 6 randomized trials comparing psychotherapy with SSRIs (5 trials) and Tricyclic Antidepressant (1 trial). Recent NICE evidence (update in Sept 2013) (NICE 2013) maintains its recommendation of either SSRIs, or more intensive CBT, for people with OCD, who have not responded to low intensity CBT or where the response was inadequate.

This is just a sampling of the fairly extensive evidence comparing the effects of psychotherapy and/or pharmacotherapy for the treatment of various disorders, such as depression and anxiety. There is a mass of evidence trying to assess the efficacy of a certain treatment (therapy or drug) for a particular disorder. This is what is "required" by NICE and similar bodies before a treatment can be properly 'approved' for use in the health service. Sometimes a treatment is not approved because of cost factors, even though it may be very efficacious.

It must further be noted that – in order for a treatment to be assessed 'properly' – with RCTs etc., there can only be a single diagnosis (e.g. anxiety, or depression, or OCD). This is an essential part of the "scientific method": the 'disorder' has to be isolated, and the treatment then applied in a "controlled" condition. You cannot, for example, include people with anxiety and depression. It is also very difficult, when using randomised controlled trials, to compare various psychological therapies as – as has been noted – they can vary considerably. CBT has an advantage here because it can be "manualised" – applied in a text-book fashion to anyone. Most other psychological therapies rely on the quality of the therapeutic relationship, which varies considerably between the individual therapist and patient/client.

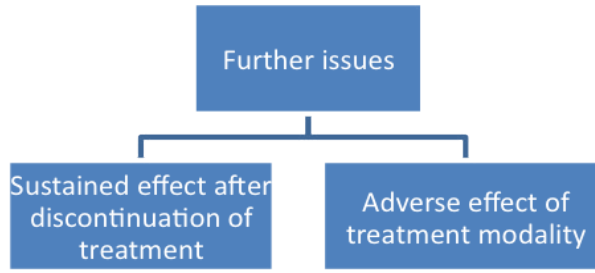
There also has to be a systematic "randomisation" process, whereby some people get chosen (at random) for the treatment and the others get a non-treatment (or placebo): this should technically be a "blind process" whereby only the researcher knows who gets the therapy and who gets the placebo. The knowledge of active treatment or placebo should also be concealed from the assessors and participants in the trial. This is much easier to do with pharmacological treatments, but is less easy (if not impossible) to do with psychotherapeutic treatments: what is the placebo – no treatment (which may not be ethical); or a chat over a cup of tea? But that may also be quite therapeutic!

There are therefore some profound and inherent difficulties in comparing these two forms of treatment – pharmacological and psychological – with the same yardstick. Critique of current meta-analytic method comparing these two treatment modalities can be found elsewhere (Klein, 2000). Funding and resource allocation for a particular intervention requires comparative efficacy and cost-effectiveness studies; and yet this remains elusive in these two modalities (PhT and PsT), a major topic of health care intervention. One way of resolving this would be to conduct a head-to-head RCT with PhT, PsT and a placebo: but logistical, ethical and practical issues would be hugely challenging if not impossible. Besides, healthcare professionals need to agree on what constitutes 'evidence'. particularly in mental health where subjective clinical judgement and assessment are often required, rather than tangible laboratory results used in many physical health issues.

Commonalities, differences and further issues

Both pharmacotherapy and psychotherapy have some common features: they both have 'patients' on the receiving end; in both, 'patients' receive a form of 'treatment', either drug or psychological therapy; and both are provided within what is seen as a specialist mental health framework (e.g. General Practitioners referring to 'professionals' like psychiatrists or psychologists). Variations do exist between professionals (counsellors, psychotherapists, psychologists and psychiatrists) in terms of competencies, skills and knowledge, but our main concern here is the concept of 'treatment'.

Leaving patient factors aside, the quality of the drug seems to remain fairly constant (i.e. a particular drug will produce (more or less) the same physiological or psychological effect), however the side-effects can be considerable and also do vary amongst patients; by contrast, the quality of psychological therapy differs more with the individual therapy and therapist, even though the overall comparative effect between all the different therapies has been argued to be quite similar (Luborsky, 1975). The qualities of the psychological therapy in the various studies are likely to be a bit better than in everyday practice. But this variability is absent with mass-produced drugs. It can also be argued that, whilst people's physiology varies a little (especially given differences between age, ethnicity and general health), their psychology varies considerably and thus a more individualised therapy (i.e. psychotherapy) may be more suitable.



Butler (Butler, *et al.*, 2006) suggests that the effect of psychotherapy lasts longer with vastly superior long-term persistence of effects, and with relapse rates being half those of pharmacotherapy. It is also a commonly held notion that drugs have many adverse side-effects, whereas psychotherapy does not. However, these issues have been challenged: Bergin's Deterioration Effect (Barlow, 2010) suggests that while some people improved substantially, others deteriorate significantly, compared to a control group with psychotherapy. And this is much too common (5-10%) to be ignored (Mental Health Group & Sheffield University n.d.). Bergin even went as far as to imply that some suicides may even be therapist-precipitated (Barlow, 2010). Some people suggest that the lack of research on the negative effect of psychotherapy is partly due to a lack of theoretical concepts on how to define, classify and assess the (adverse) side-effects of psychotherapy.

From a practical point of view, psychological therapy has some drawbacks compared to drug treatments: for example, a general lack of therapists (despite measures like the UK's 'Improved Access to Psychological Therapy'); potentially long waiting times; patients needing to travel significant distances in most areas; a reluctance to fund (or to limit funding for) psychological treatments; the significant efforts required by the patients to make life, attitude or behavioural changes; and so on. However, the rising costs of pharmacotherapy;

the development time and cost of new drugs; and the implicit and increasing 'dependence' on the drug companies, all help to balance the picture a little.

Finally, it should be made clear that comparing psychotherapy and pharmacotherapy can be like comparing (say) an apple to an orange, or even to an orang-utan: they are fundamentally and totally different. Many people who present with symptoms of anxiety and depression are not necessarily 'ill'; and therefore may not need 'treatment': they are people who have been stressed out (and/or deeply affected or overwhelmed) by a series of stressful life events and there is probably nothing wrong with them – except what has happened to them recently. Their 'depression' or 'anxiety' is often reactive, and thus exogenous, rather than endogenous and thus possibly more suited to pharmacological treatments. There may be a background of deprivation (in physical, economic, social or psychological health) that exacerbates the present stress. They may have developed unhelpful attitudes, inappropriate reactions or dysfunctional behaviours: all of which can be looked at within the framework of a psychological therapy. They may therefore need understanding, help and support; they may also need some temporary relief from the symptoms of depression and anxiety, which can be provided pharmacologically. But there are considerable dangers in the modern trend to 'medicalise' (or 'pathologise') people in ordinary (albeit difficult) life situations: and we have seen this recently in the furore about the introduction of DSM-V and also the debate about pharmacology treating the 'chemical imbalance' in the brain (Pies 2014).

Conclusions

The current evidence-base suggests that pharmacotherapy and psychotherapy (especially CBT,) are equally effective in the treatment of depression and most anxiety disorders. Pharmacotherapy seems to be slightly superior to psychotherapy for dysthymia (chronic depression of mood), while psychotherapy seems to have the advantage over pharmacotherapy in the treatment of OCD and PTSD. However, these two treatment modalities should be seen as a complementary to each other rather than competitors as there is strong evidence that the joint use of psychotherapy and pharmacotherapy is more effective than either one or the other alone.

Besides these trends, there are various other factors, such as treatment availability, patient preference, urgency, cost of treatment, motivation of the patients, social situation, age, etc. which need to be taken into consideration before making a clinical decision on or between the treatment modalities. Mutual decisions between patient and clinician, after a formal discussion on the current evidence-base and possible adverse effects, would make the choice of treatment modality more effective. Psychotherapy would be challenging, if not impossible, in patients lacking sufficient insight into their condition or situation, which is sometimes the case in people with mental health issues. While universal availability of psychotherapy is still a long way off, indiscriminate or well-nigh universal prescribing of pharmacotherapy, especially in depression, should be curtailed to avoid patients becoming "pill-poppers".

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No conflicts of interests are registered.

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Positive Psychotherapy: 'Let the Truth be Told'

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Submitted July 2013; peer-reviewed twice Oct & Dec, 2013; revised considerably, May 2014.

Abstract

Positive Psychotherapy was originally developed in 1968 in Germany by Nossrat Peseschkian. There is a version of 'Positive Psychology Therapy' originating in the United States. In a 2006 article, Seligman writes, "therapies that attend explicitly to the positives of clients are few and far between. The first we know of was created by Fordyce (1977)" (p. 775). This is inaccurate for what was really given internationally and based on the context of Fordyce's articles. This article discusses the use of the term "Positive Psychotherapy", and briefly presents the different therapeutic orientations, origins, methodologies, and applications of these fundamentally different methods.

Keywords: Positive Psychotherapy; capacities; positive psychology.

Positive Psychotherapie: "Lassen Sie die Wahrheit zu sagen"
Zusammenfassung

Die Positive Psychotherapie wurde ursprünglich, im Jahr 1968, in Deutschland von Nossrat Peseschkian, entwickelt. Zusätzlich gibt es eine Version der ‚Positive Psychologie Therapie', mit Ursprung in den Vereinigten Staaten. In einem Artikel von 2006, schreibt Seligman, " Therapien, die ausdrücklich auf das Positive im Klienten Kunden achten, sind dünn gesät. Die ersten uns bekannten wurde von Fordyce (1977, S. 775) erstellt." Das ist ungenau, was wirklich international gegeben war, basierte auf den Kontext des Fordyces Artikels. Dieser Artikel beschreibt die Verwendung des Begriffs "Positive Psychotherapie", zugleich präsentiert er in Kürze die verschiedenen therapeutischen Orientierungen, die Herkunft, die Methoden und die Anwendungen dieser grundsätzlich verschiedene Verfahren.

Schlüsselworte: Positive Psychotherapie; Kapazitäten; positive Psychologie.

Psychothérapie positive: "Que la vérité soit dite"
Résumé

La Psychothérapie Positive a été développée initialement en 1968 en Allemagne par Nossrat Peseschkian. Il existe également une version de « Thérapie de Psychologie Positive » ayant ses origines aux Etats-Unis. Dans un article en 2006, Seligman a écrit : « les thérapies qui adressent explicitement les aspects positifs des clients sont peu et rares. La première, à notre connaissance, a été créée par Frodyce (1977)» (p. 775). Ceci n'est pas exacte concernant ce qui a vraiment été donné internationalement et basé sur le contexte des articles de Fordyce.

International Journal of Psychotherapy: 2014, Vol. 18, No. 2, pp. 62-71: ISSN 1356-9082
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Cet article traite de l'utilisation du terme « Psychothérapie Positive » et présente brièvement les diverses orientations, origines, méthodologies et applications thérapeutiques de ces méthodes fondamentalement différentes.
Mots clés : Psychothérapie Positive; aptitudes; psychologie positive.

Положительный Психотерапия: " Пусть по правде говоря " Резюме

Позитивная психотерапия была создана Носсратом Пезешкяном в Германии в 1968 году. Существует также версия «позитивной психологической терапии», созданная в Штатах. В своей статье, написанной в 2006 году, Seligman пишет: «Можно по пальцам пересчитать теоретические подходы, которые обращают внимание клиентов на позитивное. Первый из известных нам подходов был создан Fordyce (1977)» (p. 775). Данное мнение основано на контексте статей Fordyce и является неточным и некорректным по отношению к международно признанной реальности. В статье обсуждаются вопросы, связанные с использованием термина «позитивная психотерапия». В ней также кратко описываются различные фундаментально различающиеся терапевтические направления, их истоки, методология, возможности использования и сферы применения.

Ключевые слова: позитивная психотерапия, способности, позитивная психология

*

The original meaning of the English word 'positive' originates from Latin, *positum*, meaning 'real' and 'given'. The contemporary use of *positive* implying "focusing on what is constructive and good" first appeared in 1916.[1] Changes of word meaning, lexical usage, is quite common and often very revealing. It is given that, if one adopts a positive mindset, strives to be aware of and develop one's capacities, what is 'given' and 'real' must be accepted; once something is accepted as being real, it is far easier to adopt a positive attitude to what is given. What are given for any individual are not just conflicts, nor just what is constructive and good, but also capacities for dealing with conflicts. Sometimes these capacities are overwhelmed and help is needed. At periods such as these, finding professional help may be of value.

Positive Psychotherapy (PPT) refers to a therapeutic modality that has been in use since 1968 in Germany and a well-founded, empirically tested technique. Dr. Arno Remmers from Germany states: "The idea of PPT came up in 1968 and was published in 1977 as such, before it was named Differentiation Analysis" (personal communication, Oct. 15, 2012). In 1977, a book carrying the title of *Positive Psychotherapie* was published in Germany, and translated into English the same year by Springer-Verlag in Berlin & New York. In the same year, the German Association of Positive Psychotherapy was founded and in 1979, the *Annual Journal of Positive Psychotherapy* (Zeitschrift der Deutschen Gesellschaft der Positiven Psychotherapie) was published. In 1986-87, Springer published five of Peseschkian's books on PPT and distributed them to US universities. Internationally there is a body of 26 published books and more than 270 articles in various scientific journals, in 23 languages.

Created by Dr. Nossrat Peseschkian, an Iranian-born medical doctor, psychiatrist and psychotherapist who lived in Germany until his passing in 2010, PPT has its roots in psychodynamic psychotherapy, humanistic psychology and cross-cultural psychotherapy. It is an *integrative transcultural* psychotherapy (Cope, 2010) that is resource-oriented and

1 http://www.etymonline.com/index.php?allowed_in_frame=0&search=positive&searchmode=none

conflict-centered that considers what is 'given', i.e. *positive*, for a client. Currently there are centers in 40 countries, recognized by the World Council for Psychotherapy and the European Union for Psychotherapy. Tellingly, there are no PPT centers in the US or Canada, though published works carrying this name have been present in university libraries for many decades.

Besides Peseschkian's method, coming out of the US-based academic field of Positive Psychology, Dr. Martin Seligman created an empirical approach for which the term 'Positive Psychotherapy' is also being used. Seligman states that Tayyib Rashid had created a version of what is being called 'Positive Psychotherapy'.[2] In a Nov. 2006 (p. 775, italics added) article carrying that title, Seligman, Rashid and Parks write,

> Indeed, *therapies* that attend explicitly to the positives of *clients* are few and far between. The first we know of was created by Fordyce (1977) who developed and tested a 'happiness' *intervention* consisting of 14 tactics … He found that students who received detailed instructions on how to do these were happier and *showed fewer depressive symptoms* than a control group.

When I was preparing an article that I presented at the 2nd Conference of Positive Psychology in Beijing China (Nov. 2012), I perused the articles by Fordyce (1977; 1983) and *did not find the italicized words* in these articles at all. The word *psychotherapy* does not appear in the 1977 article. To be patently fair, the term *therapy* does appear and one may be inclined to read into this that Fordyce did a *psycho*therapeutic intervention, but we also know this not to be the case from the content of the article. The word *therapy* is used when Fordyce states unequivocally what his experiment actually was. It was a program designed for self-change given to students (not clients) that "anyone in any situation" can learn, to increase happiness. "This ability for self-change shows that self-study programs, such as the one described herein, can become a widely useful ally to psychologists. Used as an adjunct to counseling and therapy or as an educational tool..." (p. 521). This is the only instance of the term *therapy* in the 1977 article. His research and findings can be used as *an addition to therapy*, but were not therapy or therapeutic interventions.

However, the word *psychotherapy* does appear in Fordyce's 1983 article, though again not indicating his experiment was used in a psychotherapy setting which he clearly indicated they were not; it appears when he states that his studies are "…in line with—and have relied heavily upon…" works in "marriage and family counseling, psychotherapy, self-help, behavior modification…" (p. 497). There is no mention of any therapeutic happiness intervention used for clients.

Since I knew about the form of PPT created by Peseschkian, this got me wondering if there was any mention of Peseschkian in the literature of positive psychology. I discovered there is a paucity of literature published in US academic journals on Peseschkian's form of PPT, though the late Charles Snyder, co-editor of the 2002 *Handbook of Positive Psychology,* and 2003 *Handbook of Positive Psychological Assessment,* knew of it and collaborated with Seligman. Snyder attended a World Conference for Positive Psychotherapy in Wiesbaden, Germany in 2000 and gave a keynote address, "Hope and Psychotherapy"[3]. In the 2002 *Handbook* chapter by Keys & Lopez on "Positive directions in diagnosis and interventions", the spelling to Peseschkian's name is given incorrectly as Pesechkian (2002, p. 54), though

2 On Seligman's Authentic Happiness webpage, one finds this: "Dr. Tayyab Rashid created positive psychotherapy (PPT) for depressed patients seeking treatment at Counseling and Psychological Services at the University of Pennsylvania." www.authentichappiness.sas.upenn.edu/newsletter.aspx?id=1553

3 Held on July 6th, his talk was based on the paper "The Role of Hope in Cognitive-Behavior Therapies".

the term 'Positive Psychotherapy' is clearly stated. In *Positive Psychology in Practice* (2004), Joseph and Linley also mention Peseschkian's contribution and accurately state that it does not derive from the field of positive psychology:

> Finally, there is also the positive psychotherapy developed by Peseschkian and colleagues (e.g., Peseschkian & Tritt, 1998). However, this approach is not drawn from the positive psychology tradition, but instead notes that the "positive" in its title is drawn from the word "'positum', i.e., from what is factual and given" (Peseschkian & Tritt, 1998, p. 94). Hence, while its title may be misleading, we would not consider Peseschkian's positive psychotherapy to be a positive psychotherapy within the positive psychological sense. (Ibid, p. 363)

I'm not quite sure how the "title may be misleading", however, in that those using Peseschkian's PPT clearly state what *positive* means, and *it is* a valid meaning. It is clear that Peseschkian's usage of the term positive derives from the Latin root. Perhaps they mean 'misleading' if one only thinks of the term *positive* in a post-1916 sense. Changes in terms often results in confusion unless clarified, and a term that might have been protected by copyright, such as 'kleenex', 'hoover', or 'xerox', become common parlance when such protection expires. I learned that Peschkian's term had been protected by copyright in Germany until Oct. 31, 2006.

In this article I will only briefly contrast these two methods carrying the title 'Positive Psychotherapy': the one originating in Germany in late 1960's, and the other in the US in the mid-2000's, and highlight their different therapeutic orientations, origins, methodologies, and application. This is done in the hope of clarifying confusion over these two approaches and allowing the 'truth to be told' about the term 'positive psychotherapy'.

Positive Psychotherapy (after Peseschkian)

> *"A person who is incapable anxiety, grief, depression, or occasional compulsions is not a perfect human being but rather a person whose growth has been stunted with respect to these possibilities for unfoldment"* (Peseschkian 2000, p. 373).

Peseschkian's PPT is a humanistic, psychodynamic, resource-oriented, conflict-centred approach that is explicitly integrative and transcultural. The focus of PPT is on therapeutic practice with patients/clients. It has a very clear structure that allows for short-term therapy, as well as longer-term needs. Its application to psychosomatic illness was a central feature of Peseschkian's work and his 2013 book, the English translation of his 1991 German edition, documents and provides examples of how it has been applied. Its efficacy has been demonstrated through effectiveness studies (Peseschkian & Tritt, 1998), carried out over a 5-year period, with 35 therapists and 500 clients, as a result of which Peseschkian was recognized with a prestigious award: the Richard Mertens Prize in medicine.[4] Through practice and observation, elements of PPT were investigated and operationalized. Peseschkian asserted that investigations "were based on about 50,000 psychotherapeutic sessions" (2000, p. 61).

Therapeutically, it has been successful in remedying symptoms and psychological disorders with an indication for individual psychotherapy such as depression, anxiety, sexual disturbances, stress, aggression, phobic symptoms, nervousness, stomach ailments, learning

4 Information on this prize can be found at http://www.richard-merten-preis.de/start.htm

difficulties, as well as a wide range of psychosomatic disorders. PPT has been utilized in group therapy and family therapy for disorders and conflict situations as well as child and youth therapy. In medicine, PPT has been especially helpful for general practitioners and internal medicine doctors by providing basic psychosomatic treatment methods. Outside of the therapeutic setting, it has been used as primary prevention by supplying information and training to school principals and vice-principals (e.g. in Shanghai, China; Bulgaria), school psychologists, parents groups, for kindergarten teachers (e.g. in Shenzhen China; Bulgaria), and other educational settings. PPT has also been used in business and management training, individual and group coaching, 'stress surfing' (Kirillov, 2013) as well as management techniques for school directors.

A central element of PPT is the focus on the 'positive', on what is 'given', as well as on a reframing of the illness. What is 'given' with any client are not just their difficulties, but also various capacities and possibilities for development as well. In addition, PPT considers a positive (constructive) view of illness. Peseschkian writes, "Positive Psychotherapy does not attempt to provide everything with a positive prognosis; rather it strives for differentiation of the critical behaviour" (2000, p. 402). As an example, a client presents with depression, after having seen other therapists over many years and having been told that her depression is labeled "treatment and medication resistant.' Loss of hope ensues; prospects for any alleviation of suffering diminish; and this 'prognosis' seems certain – "given". What is positive in this? Well, it is indeed 'given' that she is struggling with depression, and that this diagnosis has eliminated hope; none the less, it can be pointed out that she also has a great capacity for self-reflection, a deep emotional response to life, concern for her own welfare and that of her parents, as well as a desire to find meaning in her life. It is true that some people do not have their psychological capacities very well developed while in the case of the client these can be emphasized too much; while for her, her sense of meaning has been ignored. There is hope in that she can learn what the underlying conflicts are which draw her reflective capacity to herself and begin to broaden it to others as well as spend time thinking about life's meaning. A deep emotional response to life implies great capacity for experiencing happiness and joy by working through the unconscious conflicts and abreacting them. One is not merely trapped by the past, but can imagine new possibilities for the future.

As a cross-cultural and trans-cultural method, PPT follows a five-step therapeutic process with clear psycho-educational features: 1) observation/distancing; 2) inventorying; 3) situational encouragement; 4) verbalization; & 5) broadening of goals. This process gives structure not only for therapy, but also conflict resolution skills that can be learned by clients and applied in their own living situations, thus helping them become independent of the therapist and a 'therapist' in their own environments. To facilitate this empowerment, 'homework' is given that may range from writing letters to another or oneself, a capacity, psychosomatic ailment, practicing specific skills, or writing about a story. In fact, the therapeutic use of stories is an integral feature of PPT.

By considering *basic capacities*, the capacity to love and to know, Peseschkian realized these capacities manifest as *actual capacities*. Peseschkian researched psychological and therapeutic literature, undertook extensive research with colleagues, and settled on a list of capacities that are psychodynamically significant. They are not, however, restrictive and any therapist using PPT needs to be aware of how such capacities are expressed in different cultural settings or if other capacities may be more relevant. These basic psychological capacities are taken to be innate dispositions every person has and in order to actualize them, need differentiation. "Man is, at birth, no *tabula rasa*, but rather to stick with this image, an as yet illegible or unread paper. His capacities–the foundation of human development–

require maturation and the beneficial help of the environment" (Peseschkian, 2000, p. 54). Sometimes these capacities become sources of conflict, due to the different values given to them as well as different emphases given to them in different cultures and time periods.

The conflicts are not generally macro-traumas, but PPT considers the significance of the little daily 'infractions' called micro-trauma. These micro-traumatic events, e.g., someone not being clean enough, not thrifty enough, coming late for an appointment, etc, are value judgments based on our concepts regarding these capacities. In themselves the events are neutral, being conflictual due to one's expectations and needs. The following table lists these capacities.

Table 1 Actual Capacities

PRIMARY	SECONDARY
Love (emotionality)	Punctuality
Modeling	Cleanliness
Patience	Orderliness
Time	Obedience
Contact	Courtesy
Sexuality	Honesty/Candor
Trust	Faithfulness
Confidence	Justice
Hope	Diligence/Achievement
Faith	Thrift
Doubt	Reliability
Certitude	Precision
Unity	Conscientiousness

As a conflict-centered psychotherapy which addresses the 'positives' of clients, PPT focuses on the underlying 'real' and 'given' conflict between these actual capacities that gives rise to the symptom. The symptom is seen as an unsuccessful attempt to solve the conflict. Often the conflict originates from the values learned in one's family of origin regarding these capacities; this is considered to be a *basic conflict* and the current situation evoking such conflict reaction is the *actual conflict*. One example will help here: "If someone is not punctual, even by a few minutes, I cannot help but imagine that they do not value me and I doubt their intentions and my trust in them diminishes. When this happens, I often get very anxious and then an upset stomach and cannot understand what I did. When I was young, my mother would become so angry when I was late and she would tell me that she cannot trust me. I felt so horrible that I disappointed her and lost her trust. She would sulk and not talk to me for hours!"

While therapy could focus on the symptoms of anxiety, by differentiating the *content* of the conflict (i.e. trust, love/acceptance, hope, doubt, confidence, punctuality), PPT serves to broaden the clients' concepts regarding these values, present counter-concepts about them, help the client understand what was learned in the *past*, how it affects the *present* and consciously work to change *future* responses to the capacities of, e.g. punctuality and trust. Through such a differentiation, the client understood that she was not anxious about all facets of life or social interactions, nor that she suffered a "negative mother complex", but put too great an emphasis on being punctual and expecting this of others as well. It became a standard and ideal by which she judged relationships and her obligations.

Peseschkian's PPT utilizes well-tested inventories that are used by the therapist assess,

discern and differentiate the internal conflicts and conflict contents: the Differentiation Analytic Inventory is a listing of these capacities that are given value (indicated by – or + signs) for the client and her significant others. As well, there is the WIPPF, Wiesbaden Inventory for Positive Psychotherapy and Family Therapy, an 88-question inventory that ascertains the value given these capacities as well as information about conflict resolution, family relations as well as the active-passive dimension to capacities.

Positive Psychology therapy (after Rashid)

As mentioned above, Seligman wrote that Tayyib Rashid created a form of PPT, thus it seems important that we utilize Seligman's own crediting of Rashid's application of positive psychology to therapy. The designation, after Rashid, is meant to indicate this clearly; thus in this section PPT stands for positive psychology therapy. As well, Heffron and Boniwell (2011) state, "Many psychologists who affiliate themselves with the positive psychology movement offer ideas on how to conduct 'positive psychology therapy'" (p. 203). They refer to Rashid's 2008 article in the *Encyclopedia of Positive Psychology* as one example, though he termed the approach Positive Psychotherapy. This version of PPT seems to be more about counseling and popular application of positive psychology rather than *psychotherapy.*

Rashid's version of PPT has a fundamentally different origin than Peseschkian's. Positive psychology "is the scientific and applied approach to uncovering people's strengths and promoting their positive functioning" (Snyder & Lopez, 2007, p. 3). It began when Seligman was the president of the American Psychological Association in 1998 and grew out of his acknowledgement that western psychology had more focus on pathology than on wellness. It seeks to use "what is best in the scientific method to the unique problems that human behavior presents in all its complexity" (Seligman, 2002, p.4). The origin is academic, scientific psychology, not psychotherapy. Thus, this form of ppt is an application of the scientific method to therapeutic issues. However, since it is still young in its application, Rashid's PPT has so far been used primarily for relieving depression (Seligman et. al. 2006; Seligman 2011), though the application of PPT has also been undertaken by Kahler, et al. (2013) for smoking cessation. Seligman's 2011 book, *Flourish*, states that a book, *Positive Psychotherapy: a treatment manual* was slated to be released by Oxford University Press in 2011, though as of this writing (May 2014), it has not been published.

Based on the list available in *Flourish,* ppt after Rashid uses a 14-session approach which focuses on character *strengths*, positive emotions, forgiveness, gratitude, optimism and hope, 'savoring', giving time, and meaning (2011, pp. 41-42). Strengths are characteristics that are present in different contexts, contribute to "fulfilment of the good life for self and others" (Heffron & Boniwell, p. 197), valued in themselves, may be institutionally supported, can be differentiated and measured. They read like a list of spiritual virtues and in fact have been culled from spiritual traditions worldwide; they are categorized thusly: knowledge and wisdom, courage, love, justice, temperance, and transcendence are the main categories with finer differentiations providing 24 strengths (Snyder & Lopez, 2007). Rashid's version of ppt uses internet resources as interventions, and data collection, particularly the Values in Action Signature Strengths (VIA) available at the authentic happiness website.

There is also 'The Positive Psychotherapy Inventory' created by Rashid in 2008 "was designed to measure happiness, similar to how the Beck Depression Inventory measures depression" (Magyar-Moe, 2009, p. 84). This inventory is listed among other positive psychological interventions. It is easy to see how this inventory and the others listed by her focus on 'positive' in the post-1916 meaning of the term. Magyar-Moe's work provides a more

detailed presentation of the "idealized" 14 sessions mentioned above. When one examines the literature in approaches that apply positive psychology to therapy, there are different definitions of such positive psychological interventions, though Heffon and Boniwell (2011, p. 261) provide a definition given by Sin and Lyubomirsky that expresses what characterizes such interventions: "Treatment methods or intentional activities that aim to cultivate positive feelings, behaviours or cognitions". Such interventions do not have the intent to alleviate or heal pathology or psychological deficiencies, thus do not focus on what is 'given' and 'real' for a client suffering. This is significant in that the focus of these interventions is clearly demarcated from any psychodynamic therapeutic approaches which seek to alleviate psychological pain, reduce or eliminate pathologies, and perhaps even assist to restructure personality. The inventory by Rashid provides scores for four aspects of life: pleasant life, engaged life, meaningful life, and overall happiness.

Since there are many therapeutic applications of positive psychology, Rashid's ppt can be seen to be one among many, and a notable contribution to the growing additions that seek to further positive psychology. Homework is used which helps the depressed person focus on their strengths instead of their weaknesses and problems.

As mentioned above, Kahler has applied Rashid's PPT to individuals who wanted to stop smoking, and designated it as PPT-S. In a purported scientific research project, 19 smokers who reported low positive affect, and were "willing to use the transdermal nicotine patch" participated in the study. "Participants were excluded if they (1) were currently experiencing psychotic symptoms, affective disorder (major depression or mania), or substance use disorder other than nicotine dependence" (2013, p. 2). The authors state clearly that there was no comparison condition to assess the efficacy of PPT-S, though "Meta analysis suggest that six-month abstinence rates for the smokers receiving the nicotine patch averages about 23% (Fiore et al., 2008)" while this study demonstrated a 31.6% abstinence rate. This means 6 participants compared to 4 participants who might have remained non-smoking at six months by merely using the patch were not smoking at this point. Therefore, this version of what is being called psychotherapy helped two persons more than benefitted without it.

As intriguing as this study may be for those using positive psychology applied to various challenges of life, I am left to wonder what the definition of *psychotherapy* is that is being used. Indeed, those who smoke but had some psychotic symptom or affective disorder were excluded, yet these are the very individuals that need psychotherapy, one would think. Nowhere in the literature from, Seligman and Rashid or others who have so far applied positive psychology to therapy and used the term 'positive psychotherapy', has there been a definition offered of what is meant by the term psychotherapy. Whatever it may be (and we must admit that this term is often widely defined) it is clear that it is not a psychodynamic approach.

As stated above, the initial article by Seligman, et al. (2006) when they asserted that Rashid began an approach termed PPT, they used Fordyce's research (1977, 1983) and further asserted that Fordyce created a form of *psychotherapy* that looked at the positives of clients. He did not use clients, he used students, nor did he create any form of therapy. Thus, it seems that from its origin, the version of what is being called positive psychology therapy, or positive psychotherapy out of the scientific-academic discipline of positive psychology, is a form of psychotherapy unfamiliar to practicing therapists. Perhaps the intent is to change the meaning of this term so that it is unrecognizable and, like positive psychology, not focused on pathology. But this raises a question: why even call it psychotherapy? Even etymologically, this term comes from the Greek *therapeia* meaning 'curing, healing' or 'service to the ill', and *psyche;* and if positive psychological interventions do not address this dimension of healing

psychological suffering or pathology, it seems fair to ask if it's just pop psychology instead of psychotherapy.

Conclusion

In this article I have briefly clarified the differences between two approaches carrying the name Positive Psychotherapy. In 1977, Positive Psychotherapy originated in Germany by Nossrat Peseschkian and colleagues. From this modality, *positive* takes its origin from the Latin *positum,* meaning 'real' and 'given'. It is a conflict-centered, resource-oriented psychodynamic therapy whose efficacy has been demonstrated. It is given and real that clients do not only have conflicts but also resources that can be utilized or need to be developed or modified to adequately deal with such conflicts. There are many books and academic articles published, beginning in the late 1907's, though most were not published in the United States. Internationally there is a well-developed network of Positive Psychotherapy centers and international trainings as well as conventions. PPT after Peseschkian focuses on basic and actual capacities as well as conflicts caused by micro-traumatic events. It is one of the top five therapeutic modalities in Germany today with headquarters in Wiesbaden.

In the first decade of the 21st century, Rashid and Seligman, working out of the US based positive psychology movement, began using an approach termed positive psychotherapy as well. Taking the term *positive* from the post-1916 meaning of focusing on what is constructive and good", and originating in the academic and scientific study of personal strengths and happiness, this version of PPT is also considered to be positive psychology therapy. It is one among many approaches which attempt to apply positive psychology to counseling or therapy. There are many recent works by academics working to promote PPT after Rashid, yet so far it has been limited to cases of mild depression and smoking cessation. As one version of positive psychological interventions, there have been questionnaires and inventories created to help the counselor or researcher ascertain the effectiveness of the intervention. However, it seems that the focus on positive psycho-logical interventions may lead one to overlook pathologies or personality disorders that often are the central concern of practicing psychotherapists.

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The Truth Shall Set You Free: Saying an Honest "Goodbye" Before a Loved-one's Death

Richard Erskine

Abstract

Many people suffer from anticipatory grief before the death of a loved one. This article is based on the Gestalt Therapy premise that it is necessary to have a contactful "hello" before one can have a genuine "goodbye". It reviews some of the relevant literature, defines the premise of "unfinished business", describes the therapeutic benefits of fantasy, and provides a case example using the "empty chair" method. The psychotherapy described in this article is about creating an opportunity for the expression of feelings, making interpersonal contact, and "truth telling" before the other person dies.

Key Words: grief, anticipatory grief, Gestalt Therapy, unfinished business, fantasy, empty chair, truth telling, honesty, resolution of grief, integrative psychotherapy, Fritz Perls.

Die Wahrheit Soll Euch Befreien: Ein Ehrliches „Lebewohl" Sagen Können Vor dem Tod eines Geliebten Menschen.
Zusammenfassung

Viele Menschen leiden unter erwartender Trauer durch den Tod eines geliebten Menschen. Dieser Artikel basiert auf der Annahme der Gestalttherapie, dass es notwendig ist, eine kontaktvolles «Hallo» zu haben, bevor man ein echtes «Lebewohl" haben kann. Wir überprüfen einige einschlägigen Literatur, definieren die Prämisse von «Unerledigte Geschichten», und beschreiben den therapeutischen Nutzen der Phantasie. Ein Fallbeispiel der «Leeren Stuhl-Methode", wird angeboten. In der Psychotherapie, welche in diesem Artikel beschriebenen wird, geht es darum, eine Möglichkeit für Gefühlsausdruck im zwischenmenschliche Kontakt zu ermögliche, damit die «Wahrheit gesagt werden kann», bevor die andere Person stirbt.

Schlüsselwörter: Trauer, erwartete Trauer, Gestalttherapie, unerledigte Geschichten, Phantasie, leerer Stuhl, Wahrheit erzählen, Ehrlichkeit, Auflösung der Trauer, Integrative Psychotherapie, Fritz Perls.

La Vérité vous libérera : Dire un « Adieu » honnête avant le décès d'un être aimé
Résumé

Beaucoup de personnes souffrent d'un chagrin par anticipation avant le décès d'un être aimé. Cet article est basé sur une prémisse de la thérapie Gestalt, c'est-à-dire qu'il est nécessaire d'avoir un "bonjour" plein de contacte avant qu'on puisse avoir un "adieu" authentique. Il passé en revue quelques écrits pertinents, affine la prémisse des "affaires non terminées", décrit les avantages thérapeutiques de la fantaisie, et fournit un cas d'étude utilisant la

International Journal of Psychotherapy: 2014, Vol. 18, No. 2, pp. 72-79: ISSN 1356-9082
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méthode de la "chaise vide". La psychothérapie décrite dans cet article concerne la création d'une opportunité pour l'expression des sentiments, créant un contacte interpersonnel, et « disant la vérité » avant que l'autre personne ne meurt.

Mots clés : deuil, chagrin par anticipation, Thérapie Gestalt, affaires non finies, fantaisie, chaise vide, dire la vérité, honnêteté, résolution de chagrin, psychothérapie intégrative, Fritz Perls.

Правда должна сделать вас свободным: Скажите честное «до свидания» умирающему любимому вами человеку
Резюме

Многие люди страдают от горя, зная о близкой смерти любимого человека. Эта статья основана на том, что согласно гештальт терапии, для того, чтобы сказать человеку истинное «до свидания», необходимо установить с ним контакт «здравствуй». В статье приводится обзор соответствующей литературы, обсуждается принцип «неоконченного действия», описывается терапевтическая польза фантазии и приводится описание случая с использованием техники «пустого стула». Психотерапевтическое воздействие, описанное в данной статье, связано с созданием возможности выразить чувства, установить межличностный контакт и «сказать правду» другому человеку перед его смертью.

Ключевые слова: горевание, упреждающее горевание, гештальт терапия, незавершенное действие, фантазии, пустой стул, сказать правду, честность, разрешение горя, интегративная психотерапия, Фритц Перлз.

*

Before the death of a loved-one, some clients suffer from a variety of symptoms related to grief. These grief related symptoms may include denial, bouts of intense sadness, often alternating with periods of emotional numbness, confusion, avoidance of, or anger at, the dying person, repetitive arguments, a general sense of helplessness, or feeling overwhelmed and stressed. Many people experience intense anticipatory grief before a loved-one dies.

John Bowlby (1961, 1980) was one of the early psychologists to study the process of mourning and described grief as resulting from the loss of attachment. Parkes (1972), and later Parkes and Weiss (1983), made use of Bowlby's ideas about attachment and loss and proposed a theory of grief that included four stages: shock-numbness, yearning-searching, disorganization-despair, and reorganization. Kubler-Ross (1969) popularized the idea that grief occurs in distinct stages and outlined five stages: denial, anger, bargaining, depression, and acceptance.

Axelrod (2006) makes the point that not everyone will experience all five stages of grief, and that it is not necessary (or expected) that one will go through the stages in any particular order. The Yale Bereavement Study (Maciejewski, et al., 2007) examined the concept of stages of grief and found that many people seemed to progress through various stages and that *"yearning was the dominant negative grief indicator"* (p. 716). Recently Friedman (2009) challenged the notion of stages of grief as a simplistic taxonomy that does not allow for individual variances in the process of grieving. He suggested that each person grieves in his or her own unique way.

When clients experience anticipatory grief, they may exhibit some of the same psychological dynamics described by 'stage' theorists, but their emotional reactions do not seem to pass through distinct stages. In my clinical experience, clients experiencing anticipatory grief often display a mix of emotional reactions. With some clients, there is an orderly progression from one emotion to another. With other clients, their emotional

reactions seem to oscillate from one extreme to another in a matter of minutes. They may be resentful, appreciative, despairing, openly angry, nostalgic, compliant with family traditions, and/or also yearning for some words of acknowledgement or love. Frequently, grieving clients will focus on one specific emotion and disavow other thoughts and feelings. Whether we organize our psychotherapy to attend to each "stage" of grief, or instead focus primarily on our clients' emerging experiences of emotions, our clients often need us to attend to their "unfinished business" with the dying person.

Other authors, writing on the therapeutic treatment of grief, have focused on various treatment models (Clark, 2004; Hensley, 2006). These models emphasize: accepting the loss: the treatment of anger and despair; understanding the necessity for supportive and caring relationships; providing a suitable amount of time for healing from the loss; and developing new interests and activities (Greenwald, 2013; Wetherell, 2012); the use of expressive methods in the resolution of grief (Goulding & Goulding, 1979; Perls, 1969, 1975); attention to the need for supportive relationships in the family, in therapy, and in the community (Olders, 1989); and how grieving may potentiate other mental health issues (Greenwald, 2013). However, the psychotherapy literature does not seem to address the treatment of grief that may occur in anticipation of the death of a loved-one.

Sigmund Freud (1917) addressed the topic of grief by clarifying the difference between mourning and melancholia. He describes melancholia as being 'marked by an ambivalent relationship where there is a love and hate reaction to the other person that is often accompanied by anguish and a diminished sense of self-esteem; it is pervasive, unconscious, and continuous'. He describes mourning as a common and regular "reaction to the loss of a loved person" (1917, p. 243).

Freud goes on to describe mourning as a conscious response to a specific death. Unlike melancholia, he considers mourning non-pathological because it is a normal reaction to events and is generally overcome given enough time. During the mourning period, the person realizes that the loved person is truly gone, an acceptance of the loss eventually occurs, and slowly the person returns to their customary way of living.

Fritz Perls (1975), in teaching about the psychotherapy of grief, defined grief as "unfinished business" and used his "empty chair" method to help the client gain "closure" on his or her grief. He made a distinction between pseudo-grief and genuine grief. He defined 'pseudo-grief' as, "feeling sorry for one's self" and "holding on to unexpressed resentments". He challenged clients to develop "self-support" and take responsibility for living in the "now". When clients expressed genuine grief, he considered it a natural process of mourning the loss of someone and responded with genuine concern.

I learned about the psychotherapy of grief while watching Fritz Perls use his "empty chair" method to help people complete what he called the "unfinished business" of grieving (Perls, 1967). Perls would ask the grieving person to use the "empty chair" and fantasize that the significant 'Other' was sitting in front of him or her. He would then encourage the client to speak to the image of the other, just as though they were actually sitting in the chair, and to be fully vocal, and to use body gestures that conveyed the fullness of their emotions.

When teaching about the psychotherapy of grief, Perls accentuated how grief was maintained by 'holding-on' (a physical retroflection) to old resentments and anger. He also highlighted the importance of unexpressed appreciations. He taught that the resolution of grief is in the expression of both resentments and appreciations. However, in practice, Perls often gave greater consideration to the grieving client's expression of anger and resentments, than he did to the expression of appreciations. In both *Gestalt Therapy Verbatim (1969)* and *Eye Witness to Therapy (1975),* Fritz Perls provides numerous examples where he also used

the "empty chair" method to resolve client's psychological conflicts.

In the early 1970's, a few Transactional Analysts who had trained in Gestalt Therapy with Fritz and/or Laura Perls began to use the "empty chair" technique to facilitate a client's resolution of "unfinished business" – the psychological issues related to either archaic or current interpersonal conflicts. Erskine and Moursand in *Integrative Psychotherapy in Action (1988/2011)* provide several clinical examples that illustrate both the use of the "empty chair" method and the integration of a variety of Gestalt Therapy interventions with Transactional Analysis and contemporary psychoanalytic theory. Bob and Mary Goulding, following Perls' examples, included a section in their book *Redecision Therapy (1979)* that illustrates the use of the "empty chair" method to resolve what they also call the "unfinished business" of grief (p.174-184). Their brief therapy vignettes show that they also emphasise resentments and anger and give only cursory attention to appreciations.

Although Fritz Perls gave most of attention to the expression of anger and resentments, I have personally found it necessary to create a therapeutic balance between emotional polarities such as: unacknowledged anger, resentment, and bitterness on one side of the scale; and unrealized dreams, precious experiences, unexpressed affection, and loving memories on the other side in order to make it easier for the client to balance things out. I organize my therapeutic interventions to interweave each of these many emotions into the relational discourse. Sometimes, we focus on one emotion until it is well expressed, then I may draw the client's attention to another end of the emotional spectrum, and then back again, always searching for and interweaving the unexpressed emotions, striving for a healing balance.

The Premise of "unfinished business"

Intimate and meaningful conversations are essential in the resolution of grief; ideally such intimate conversation would occur before the actual death of a loved-one. After the death of a loved-one, the grief is often potentiated by "unfinished business" – the emotional pain of what had happened and/or the regret of what never happened – and thoughts of "I wish I had said more", "If only we had had a real conversation", "I never told him (or her) how much he (or she) meant to me", or "I never really told them the truth about myself". When intimate and honest conversations happen before the death of a loved-one, the grief, after the death, is much easier for the remaining individual to assimilate and resolve. When such meaningful conversations do not happen before the death of the loved-one, the after-death experience of grief is often intensified and prolonged.

The psychotherapy technique described in this article is about creating an appropriate opportunity for the expression of feelings, making interpersonal contact, and "truth-telling" – ideally before the other person dies. It is based on the Gestalt Therapy premise that it is necessary to make "full contact", to have a real "hello", before we can say "goodbye" (Perls, Hefferline & Goodman, 1951). Ideally, I prefer that the psychotherapy pave the way for sincere face-to-face conversations between my client and the dying person, while he or she is still lucid. Many clients need a significant degree of encouragement and therapeutic support in order to engage in a meaningful dialogue with the 'Other' person. For some clients, our psychotherapy provides an emotionally filled rehearsal (or practice session) that makes intimate and honest communication more possible before the loved one dies.

In some situations, the actual expression of true emotions, full interpersonal contact, and expressing one's own "truth" to the other person is not a viable option. The other person may be in a coma, suffering from dementia, or be emotionally unable to have a meaningful conversation. Because of intrapersonal scripts and long-held beliefs such as, "I have no

right to say what I feel" or "Others are more important than me", many clients are extremely reluctant to initiate such intimate and meaningful conversations (O'Reilly-Knapp & Erskine, 2010). However, there is often a hope that they might happen, or an existing grief that they haven't happened – yet.

Clients may be inhibited in communicating meaningful experience because they believe that being honest with the other person will upset, hurt, or even possibly kill him or her. Many families have forged a system that does not allow for such intimate conversations. At the time of the impending death, the loyalty to such a family system may even be intensified. In each of these situations, it may be therapeutically possible for the psychotherapist to facilitate a meaningful conversation – in fantasy – by using the "empty chair" method. In working with the client's fantasy, through the client imagining the other person sitting directly in front of him or her, we can create the possibility for a plausible interpersonal contact – contact that may not be possible in reality – thus an imaginative contact, but one that can conceivably heal deep relational wounds.

The resolution of grief involves restoring the individual's capacity for full internal and interpersonal contact – the capacity to say an authentic "hello" before a genuine "goodbye". When working with unexpressed experiences, it is important that the person fully gives voice to their many different internal feelings, needs, thoughts, and assumptions that have never been properly expressed. This is what my clients call "truth-telling" – it is the verbal (and sometimes physical) expression of the unsaid, and often unacknowledged feelings, thoughts, attitudes, associations, and reactions that the person has kept locked-up internally. Telling one's own "truth" – one's personal narrative – is an essential factor in making sense of a complex relationship, completing significant unfinished experiences, and providing an end to (or reduction in) grieving (Nelmeyer & Wogrin, 2008). "Truth-telling" is not about the citation of facts or verifiable information that can be confirmed by others. It is a "narrative truth", the expression of one's own internal experiences and his or her personal endeavours in order to make emotional 'meaning' (or sense) out of those experiences (Allen, 2009; Burgess & Burgess, 2011).

"Truth telling" involves translating affect, physiological reactions, and relational experiences into language and expression and honestly stating or sharing what may have never been expressed in a significant relationship. Many clients are not accustomed to sharing their private thoughts. I encourage clients to speak with candour and physical expression. Such "truth-telling" is the opposite of the inconsequential conversations (platitudes, business, gossip, 'safe' topics, etc.) that many people have throughout their lives. Inconsequential conversations begin as self-protective measures to maintain an emotional relationship but, over time, they can erode intimacy and interpersonal contact; they might even inhibit the expression of Self in the relationship. When we psychotherapists emphasise "truth-telling", we are inviting the client to attend to, and express, the interrupted expression of feelings, attitudes and physical gestures. It is these interrupted or withheld gestures, words, and affects that interfere with the capacity to say "hello" and "goodbye".

A Case Example

Jason's brother, Andrew, had a brain tumor. He had been in a slow process of mental and physical deterioration for over two years. As his only living relative, Jason had, for the past two years, assumed the responsibility for his older brother's living arrangements, medical care, and financial needs. A year before, the doctors predicted that Andrew would die within a month or two. Instead of dying, Andrew continued to live but his physical capacities had worsened.

Jason is a member of a psychotherapy group that meets for one six-hour day each month. He has attended the past 13 such monthly sessions. In the sixth and seventh sessions, he talked to the group members about his brother's illness and about his frustration and exhaustion in continually having to care for his brother. Jason reported to the group that, through the relational group process, he had felt understood, supported, and encouraged and thus more able to continue his responsibilities for his brother. I had also encouraged him to have several "truthful conversations" with Andrew.

In the eleventh session, Jason reported that he found it "impossible" to say anything meaningful to his brother. He again expressed to the group his despair and his annoyance at Andrew and he told the group that he wished his brother would "get it over with and die". He then wept, and said that he yearned for his brother to say "some kind words to me" or to "just show that he loved me".

In this, the thirteenth session, Jason began by saying that his brother could no longer speak or even feed himself. Jason had now lost all hope that Andrew would acknowledge him in some loving way. Jason was despondent; his body was rigid. I asked Jason if he was willing to use the "empty chair" technique to have a "heart-to-heart" talk with Andrew. At first, he was reluctant to imagine his brother sitting in front of him, or to express what he was feeling. I assured him that I and the other group members were there to support him and help him express any, or all of the feelings towards Andrew and about himself that he had rigidly held inside. His tight fists revealed some of his unexpressed emotions. I pointed out that, in previous sessions, he had made some angry and caustic comments about his brother that I thought might have represented some degree of unresolved resentment. After some group discussion about his body tension, he agreed to experiment with visualizing his brother and to tell him honestly about their relationship.

We began with my using a quasi-hypnotic introduction: "Jason, close your eyes and imagine your brother is in his hospital bed, with perhaps only 30 minutes to live. He can hear you fully, but he cannot talk. This is your last opportunity to say all the important things that you have never said to him. The important point is that you be truthful and not leave anything out. I will be right here to back you up. Just look at his image (in your mind's eye) and tell him the truth about your relationship."

Jason hesitantly told his brother how much he had always admired and loved him. I encouraged him to keep talking to the image of Andrew and to tell him everything. He told Andrew how he had looked up to a brother who was 5 years older and very athletic. As he started to talk about Andrew in the third person I encouraged him to keep visualizing his brother and to "talk to him" directly. He went on to tell Andrew how he had longed for "good times" with him. I prompted him to talk about some of the "good times" and mention some of the important things that they had done together. Jason had great difficulty recalling any pleasant moments, though he described some of the games that they had played together and the one time when his brother had defended him from a bully on the playground.

Jason was struggling to recall shared experiences that were pleasurable or intimate. SO, I suggested that he switch and tell Andrew what was missing in their relationship. Jason expressed his yearning for a "kind and loving" brother. He spoke about how he, as a boy, waited for Andrew to come home and play with him. He expressed how disheartened he was that Andrew had either ignored him, or even sometimes hit him. Jason described bitterly how, as a boy, he had longed to share a bedroom with Andrew, but how Andrew had actually "tortured" him. He went on to tell his brother how, as an adult, Andrew had misused him by borrowing money and not repaying it; how he expected Jason to take care of his "financial mess", but never said "thank you".

Jason's face had turned bright red; the veins in his neck were bulging; his fists were pushing against his chair. It was clear that he was physiologically still containing his anger. I put a large cushion on the chair and suggested that Jason begin each sentence with the words, "I don't like it that ..." Jason began to shout out several things that he detested. He hit the cushion and screamed at his brother, "I don't like the way you have always treated me" and reiterated several painful events in their relationship. He then added, "I have always loved you. I always wanted you to like me. I hate the way you used me and treated me. I have always kept quiet and waited for you to be good to me. Now I know that you will never change."

He continued to shout and pound the cushion for a few minutes and then he began to weep. He said many of the same things again, but this time he was full of sorrow. He lamented, "I longed for you to be my brother but most of my life you hated me. I have been so good to you, but you never acknowledged it. It is time for me to say goodbye now to all my hopes. I will never have the brother I wanted. You have been a real shit to me. Now I want you to die and to get all this torment over with. Go now! Find the peace you never had in life. It is my time to be free of you. I want to be with people who like me." Jason's body relaxed and his face returned to a normal colour as he quietly cried for several minutes. Later in the day, he looked much livelier. The next day he telephoned to say that he had had the best night's sleep in two years.

Conclusion

The case of Jason illustrates the transformative power of "truth-telling" and the importance of actively expressing emotions that have been, until now, inhibited and contained through emotional constraints and physical tensions. The therapeutic use of imagination, the "empty chair" method, and the psychotherapist's caring and supportive involvement, all provide the client with an opportunity to have a quality of interpersonal communication, at least in fantasy, that has not yet been possible in their reality.

Earlier in this article, I outlined several models for the treatment of grief that are described in the professional literature. The case example used in this article illustrates the integration of a number of these therapeutic approaches, most notably:

The acknowledgement of disavowed feelings;

The use of expressive methods in the healing of emotional pain and anger;

Providing the time and space for the person to tell his or her story and to finish any "unfinished business";

Providing a supportive relationship by way of the group members' and psychotherapist's involvement; and,

Assisting the client's movement through various emotional responses: such as denial, despair, yearning, anger and the reorganization of a sense of self.

In my years of treating clients suffering from anticipatory grief, I have found that it is often necessary for the client to establish a balance between: the emotional polarities of anger, resentment, and bitterness, with memories of precious experiences, unexpressed affection, and love. As described in this article, "truth-telling" to the "empty chair" is an effective method for the resolution of anticipated grief. It is essential that the psychotherapist can encourage and support the client's "truth-telling", whether it be only in fantasy to a mental image in an "empty chair", or whether eventually it is face-to-face with a real person. The purpose of this type of psychotherapy is to restore the individual's capacity to have an honest and meaningful "hello" before engaging in a genuine "goodbye".

Author

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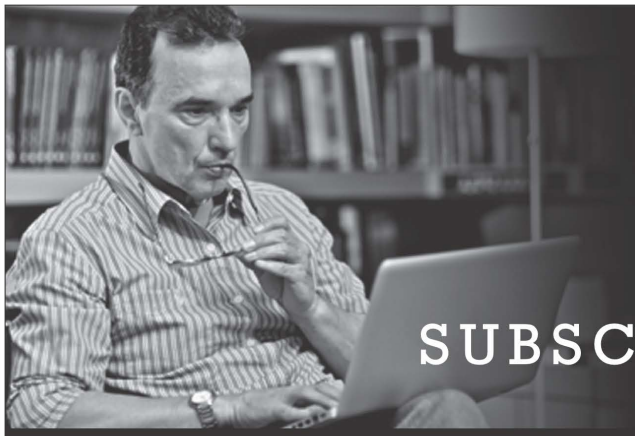

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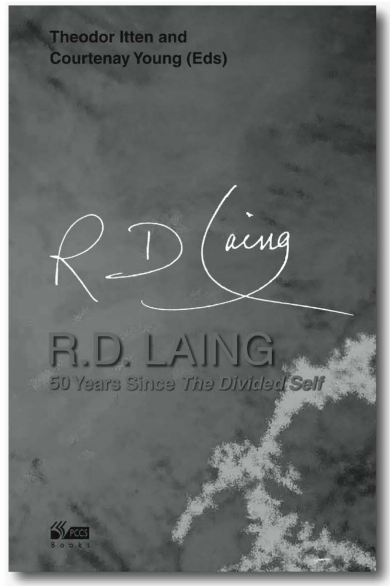

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Theodor Itten is a Swiss psychotherapist who trained, in the 1970s with R.D. Laing and The Philadelphia Association in London. He runs The International R.D. Laing Institute and is Executive Editor of the *International Journal of Psychotherapy.*

Courtenay Young is a psychotherapist working in the NHS and privately in and around Edinburgh. He is currently the editor of the *International Journal of Psychotherapy.*

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