Psychotherapy: The view from psychology

In my previous column, I drew attention to how differently the psychology profession approaches the training of new practitioners, compared with how they are trained in stand-alone counselling and psychotherapy courses. A new textbook exemplifies many significant features of this difference.

The authors of *Psychotherapy: An Australian Perspective* are all practising clinical psychologists, and teach in the School of Applied Psychology at Griffith University. They have produced a clearly organised, mostly well-written survey of the knowledge they consider relevant to intern psychologists, in the context of APS guidelines on ethical practice, and legislation on mandatory reporting and associated issues. The authors make a creditable attempt to guide tyro clinicians through the maze of research evidence on matters such as the efficacy of specific therapeutic factors. The text is supported by 16 short video demonstrations, available online via YouTube, which illustrate a range of commonly encountered issues in clinical practice, and throughout the text there are questions for discussion. The one glaring omission, given the book's title, is that hardly anywhere in its 400 plus pages would students find out *how to do psychotherapy.*

Readers of *Psychotherapy in Australia* may find this odd, but it exemplifies what psychology terms the 'scientist practitioner model'. In this model, what students must first master is the *knowledge built up by research.* Irreverently, but inescapably, into my mind comes Hugh Lofting's lines from *The Story of Doctor Dolittle — 'M.D. meant he was a proper doctor, and knew a whole lot'.* For academic psychologists, the 'scientist' aspect of the scientist-practitioner model necessarily comes before the 'practitioner' aspect, because it is 'knowing a whole lot' that puts a psychologist on the same plane as the medical doctor. Perhaps if psychologists were better schooled in the history of medicine, with its centuries of dedication to useless (even harmful) practices — supported of course by the accumulated 'knowledge' of the period in question — they would be a little more cautious in invoking medicine as the model of evidence-based practice!

Accordingly, *Psychotherapy: An Australian Perspective* puts much emphasis on helping the fledgling psychologist with what she or he needs to learn about ethics, risk management, model-specific and common factors in the change process, intake, assessment and diagnosis, and client diversity. From this varied and complex body of knowledge and accepted 'best practice', the beginning psychologist is, presumably, expected to deduce a coherent set of practices and principles for working with people in distress. Unfortunately, however, practices and principles do not supply the organising structure of the book — again, the 'science' must come before the 'practice'. In their Introduction (p.x), the authors do list a set of very broad principles for guiding the practice of psychotherapy. These include *'in therapy, the client always comes first',* with which I agree heartily — yet such principles are obscured promptly by a mass of detailed evidence in the pages that follow.

How, for example, is a beginning psychologist to make anything coherent out of the survey of no less than fourteen 'theoretical frameworks' (models of therapy) in Chapter 7? Each model gets just a few pages, and can hardly convey more than a summary that begs more questions than it answers. And rarely — except, of course, in the summary of the Person-centred approach — is the principle that *'the client always comes first'* a point of reference. The piece on Dialectical Behaviour Therapy uses the term 'dialectic' without ever explaining what it actually means, and I cannot imagine a student would finish reading it with much understanding of how DBT looks and feels like in practice. The piece on systemic family therapy relies heavily on textbook surveys of the evolution and diversification of family therapy, and misses the key point that systemic family therapy does not necessarily involve conjoint meeting with whole families, and may be conducted with an individual. In this respect, a useful comparison could have been made with Interpersonal Therapy — a recent psychological approach where individuals are coached to interact differently with significant others in order to increase their levels of social support — but unfortunately, the convergence is not noted.

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It would have been much more helpful to show students the key ways in which approaches that are apparently very different, with bafflingly distinctive terminologies, actually converge on certain key principles. A text such as Teyber and McClure (2011) is an excellent example of how to do this, producing a workable synthesis of common concepts drawn from psychodynamic, person-centred and existential therapy, in the form of actual interventions that students can employ. Notably, they constantly refer students back to the principle that 'the client comes first', and the associated principle that all interventions must be *client-specific* rather than 'one size fits all' formulas.

It occurs to me that instead of starting with theoretical models, and then teaching the interventions through which they are typically implemented, it could make more *educational* sense to start with a variety of interventions used widely by therapists, and ask what such interventions are designed to accomplish. This, in turn, would lead to how different therapeutic models would explain and justify them. For example, we could take interventions like *'Stay with that feeling… what do you notice?'* Or, *'So one part of you wants this very much, but another part seems quite uncomfortable about that',* and help students examine the assumptions that underlie them. Different theories might provide different rationales for the same intervention, leading to productive discussions of whether or not it is vital for particular 'techniques' to relate directly to particular theories, and the actual

function of theories as 'maps of the territory'.

Consistent with the medical Hippocratic Oath (*'First and foremost, do no harm'*), O'Donovan and her colleagues begin their text with a chapter on ethical practice (pp. 14–36). This might seem logical and sensible (surely students should begin by learning what *not to do,* and how to avoid being sued or deregistered?). However, to begin in this way places the emphasis on risk, on potential damage (to clients, to the professional), on inclusion and exclusion (what is 'correct' and what is 'inappropriate'). This is as if to signal that being a psychologist is about *purity and danger*, as described by social anthropologist Mary Douglas (1966/2003) in her landmark work on rituals that safeguard groups of humans against risk by insisting on rules of 'cleanness', like those listed in Leviticus.

Beginning with ethical guidelines may seem intuitively better than tacking them on the end of a text (as if they don't matter much) and is certainly consistent with psychology's findings about the 'primacy effect' — yet to my mind, the best *teaching* order is to introduce ethical issues and dilemmas gradually. If the readers of this book are still sitting in a classroom, having never yet tried their hand with a real client (or even a role-played one), ethical questions will not be fully grasped. If anything, they will give rise to anxiety in response to hypothetical scenarios that are far in advance of the student's coping ability (at this early stage). Only when students have begun to engage with real clients will they sense their own ability to inspire trust and openness (as well as learn the ways clients have of protecting themselves against inappropriate or mistimed interventions). They will then be better equipped to discuss scenarios involving risk and danger without feeling anxious and overwhelmed. This is just one example of where the seemingly 'logical' order of topics may not be the order that students need — somewhat similar to the situation in which today's psychologists are urged to explain to new clients, in the very first session, what kind of treatment they offer, how long it will take, and what the risks of it are — all this to clients who are already on edge, unsure of whether they are 'going crazy' or not, and certainly aren't yet ready to offer informed consent, even if they genuinely want to!

To be fair, O'Donovan and her co-authors are more flexible than this (see pp. 211–212), listing only six subjects that it would be normal to discuss initially, and indicating the need to adapt assessment and organisational requirements to the client's apparent needs and priorities (contrast the equivalent chapter in *Cognitive Behavioural Counselling in Action* by Trower, Jones, Dryden and Casey (2011), which prescribes so much initial explanation by the psychologist that I doubt if the client would be left with ten or fifteen minutes of the session to explain what has brought him or her to therapy).

In *Psychotherapy: An Australian Perspective*, the authors struggle creditably with the gulf between theory and practice, between 'rules' that sound sensible, yet are sometimes designed more to safeguard the practitioner than to make things safer for the client, between the ideal session, in which everything goes reassuringly according to plan, and the reality that client needs and priorities often upset such plans. Such gaps and contradictions are not, of course, confined to psychology — we all face them, all the time — but they are exacerbated by psychology's insistence that a credible therapy must be based on research evidence.

Science requires the incremental building-up of knowledge from individual investigations, each of which yields findings that are inevitably limited in themselves, and most drastically constrained when the subject of investigation is human beings. Often, the experimental evidence appears to contradict itself — this may be simply because like is not being compared with like — and the conventional scientific way of dealing with this is to acknowledge the contradiction, and admit that scientific investigations have not yet yielded the truth.

However, would it not be possible (at least some of the time) to explain seeming contradictions in terms of *broader principles that might embrace both possibilities*? I have drawn attention before to the work of British psychologist, Richard Benthall, whose masterly volumes on mental illnesses and their treatment do exactly that (Crago, 2012). Unfortunately, however, the ability to synthesise multiple research findings into a 'big picture' is not the strength of psychology as a whole, given that it tends to favour the perspective of the brain's left hemisphere over the right (Crago, 2012, p. 62–64). This is particularly a weakness in the domain of clinical psychology, since clinical psychology seeks to forge an effective *therapeutic method* out of scientific research — 'evidence based practice'. By definition, it must ignore any principle or technique that does not appear to rest on scientific principles, or which has not been proven effective in clinical trials. Yet doing psychotherapy requires broad principles, and particular practices consistent with them. It requires self-awareness and disciplined sensitivity to others, to employ those practices. These capacities are not amenable to testing via conventional experimental methods. Does that mean they are invalid? Not necessarily.

A successful textbook of psychotherapy like Teyber and McClure (2011) presents students with clear guidance on *what to do*, and while some of these guidelines are certainly supported by evidence, others recommend themselves because they represent a convincing synthesis of the principles independently discovered by a handful of ground-breaking therapists like Carl Rogers, Harry Stack Sullivan, Karen Horney and Irvin Yalom. Teyber and McClure (2011) are wise enough to focus students on what different modalities have in common, rather than on differences in terminology and conceptualisation that will simply confuse them. That, however, is a right hemisphere derived capacity — for the right hemisphere sees the 'wood' rather than the 'trees' — and one that the discipline of psychology tends not to foster.

O'Donovan et al's short chapter on microskills (pp. 223–238) is the one place in *Psychotherapy: An Australian Perspective* where the authors directly address an aspect of 'doing psychotherapy'. Hence it is revealing of the limitations, not just of this text, but of the official position of psychology itself. The microskills derived from the practice of Carl Rogers via Robert Carkuff are essentially a breaking-down of the global capacity for empathy into particular forms of words — empathic paraphrase, open question, summary, empathic confrontation, and the often-misunderstood 'immediacy'.

There are several key problems in teaching microskills. First, some of them (though definitely not all) are actually things that empathic people do automatically, and in that sense, only need to be 'taught' or 'practised' by those to whom empathy does not come readily. 'Minimal encouragers' definitely fall into this category, but so do 'attending skills' — many of us *naturally* lean forward or seek eye contact when we are very involved with the person we're listening to, just as many of us *automatically* monitor the talker's comfort with

our degree of eye contact, proximity, and so on. For such trainees, the conscious following of 'rules' of 'attending behaviour' can get in the way of their natural listening behaviour and result in *poorer* listening (at least at first).

Second, without the capacity for empathy, none of these 'skills' are going to be effective. Empathy is the right hemisphere governed capacity that *suffuses* the skills, without which they can only be mechanical verbal (or non-verbal) 'formulas'. It is the same as the difference between a monochrome image and the same image in full colour. In both ways, the left hemisphere driven *conscious learning* of 'new rules' can sometimes be ill-suited to a right hemisphere governed *instinct* for what is appropriate. O'Donovan and her co-authors avoid this pitfall, acknowledging empathy as primary — this is the kind of thing a textbook must spell out, rather than leave to the imagination, because many beginning clinicians will not 'get' it otherwise.

Finally, while many microskills do need to be taught early in the training process, this gives the false impression that they are merely a preliminary to the 'real work' of counselling (e.g., see Trower et al (2011), where they are summarised briefly in a chapter called *'Breaking the Ice: Screening, First Meeting, Establishing a Bond'*). Failure to relate the skills (in particular, the crucial capacities for empathic paraphrasing and immediacy) to the stages of the unfolding therapeutic process is a significant omission, because they remain vital throughout the process. Similarly, in discussing open and closed questions, O'Donovan and her co-authors do not point out that, other things being equal, closed questions are least useful in the opening sessions, and most useful when therapists are familiar with many aspects of their clients' stories and 'interpersonal schemas' — that is, after many sessions. Rarely is an enduring 'bond' established in a single session, and as research shows, its strength is often proportional to the degree to which that bond has been temporarily ruptured and then repaired — a process in which the *therapist's capacity for immediacy* is crucial (Crago & Gardner, 2012).

Significantly again, O'Donovan et al's list of microskills fails to include immediacy (roughly equivalent to 'here and now' intervention, or 'transference interpretation'). While 'immediacy' is referred to a number of times in the volume as a whole, nowhere do the authors actually show students how it is done, or how it differs from simply asking a client, *'What are you feeling right now?'* — an extremely common 'watering down' of the essence of immediacy, and one that leaves the therapist in the secure position of 'expert questioner', instead of rendering him/herself vulnerable alongside the client.

And surely microskills are a *foundation* shared by both counselling and psychotherapy? In a text that includes only the term *psychotherapy*, the appearance of microskills without 'macroskills' is worrying. To be sure, macroskills — which would include crucial things like the *timing* of interventions, the ability *to move flexibly back and forth between 'there and then' and 'here and now'*, and *interpretation* (the sensitive highlighting by the therapist of something that may still be hovering on the edge of the client's conscious awareness) — are only developed through experience and good supervision. I would have expected they might at least be discussed, albeit in an anticipatory rather than a prescriptive way. After all, any trainee who works with a client for longer than a couple of months will have the opportunity to start learning these capacities, which become central to any longer-term therapeutic relationship. A text that does not really offer a map, however tentative, of what psychotherapy rightly involves (as contrasted with short-term psychoeducational intervention) risks confusing 'psychotherapy' with counselling.

Given much of *Psychotherapy: An Australian Perspective* is a summary of research findings rather than a systematic set of therapeutic principles and explanations of how to put them into practice, and given the chapter on microskills is the only significant acknowledgment of the latter, the authors' chapter on supervision becomes even more important — perhaps reflecting professional psychology's reliance on clinical supervision to cover almost all the 'how to' teaching that this textbook omits. So it's important we look closely at what the relevant chapter includes. Here I was disappointed to find a good deal of emphasis on the *anxiety* that supervisees feel at the idea of being supervised, their concern at the idea that their supervisor may be *evaluating* them, their resistance to being open with their supervisor when openness might render them vulnerable, and their rights to *complain* about inadequate supervision. The picture that emerges is one of highly insecure trainee therapists and unempathic or 'by the book' supervisors, of supervision as a professional duty or even an initiation ritual, rather than a steady source of empathy, reassurance and constructive criticism that encourages students to feel pride in their growing capacities for helping their clients.

The central point — never spelled out by the authors, although there by implication — is that a good supervisory relationship must feel 'safe' in much the same way as a good therapeutic relationship, and this safety is created within supervision in much the same ways as it is within therapy; by careful listening, by supervisors who place the supervisee's interests and needs before their own, by empathy and encouragement and (when the alliance is strong enough to bear it) by respectful challenge of inappropriate or unhelpful practices. While I agree that training and supervision are not identical with therapy (and have said so many times in these columns), it makes little sense to conceptualise the position of anxious beginning therapists, just embarking on a lengthy and challenging enterprise, as fundamentally different from the position of anxious beginning clients, just embarking on an enterprise just as challenging, and probably even less well understood. Here was a great opportunity for the authors to put it squarely to their readers: *'In supervision, you're going to feel pretty much what your clients feel when they're sitting with you. If you think about your own fears and hopes around supervision, you'll have more appreciation of what your clients are going to be feeling. And if you sometimes feel shamed, or stupid, or inadequate in the course of a supervision session, you'll realise how easy it is for your clients to feel similarly in response to something you've said or done'.*

The splits and contradictions I see evidenced in this volume are emblematic of those within professional psychology itself. Psychology emerges as hierarchical, rule-governed and risk-averse, valuing content over process, and 'technique' over relationship. Any established professional 'guild' (I use the medieval term advisedly, because guilds were defined not only by specialised expertise, but by *exclusivity*) is probably guilty of such things. Emerging professions, such as our own, will need to work very hard indeed to avoid them. Part of doing so will be an open acknowledgement of our own shortcomings, which are as real as those of psychology.

Just as left hemisphere psychology has fallen in love with evidence and technique to the detriment of therapist self-awareness and sensitivity, counselling and psychotherapy have been only too willing to substitute *faith* for reasoned enquiry and clinical 'success stories' for evidence-gathering, and to assume that expressed emotion is automatically a good thing (*It must've been a good session, 'cos she*

cried'). Notoriously, we have also been unable, or unwilling, to test our convictions by systematic gathering of evidence derived from case studies reported in uniform formats (Campbell, 2003; Fishman, 2003). No wonder psychology is sceptical of our claims, no wonder psychology lecturers mutter about 'witch doctors' and 'spaghetti therapy'. We need some of psychology's caution and respect for evidence, just as psychology needs more of our holistic sense of the client-therapist encounter, and our insistence on counsellor self-knowledge and sensitivity. As family therapists used to remind each other, the solution is never to be found in 'either/or' thinking, but in 'both/and'.

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