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- Powerful, seductive and alluring? Money in private practice
- A simulated interview with William Glasser: Part 2 – The Process of Psychotherapy
- Can't we just talk to each other? Supporting Couples to Improve their Communication
- A World of Dichotomies: Empirically Supported Treatments or the Common Factors?

Road to Recovery

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Contents

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From the Editor:

Dear Colleagues,

We wish you a very warm welcome to the Winter edition of the Irish Journal of Counselling and Psychotherapy. As I write, the clocks have just been set back for winter time, day length is diminishing rapidly, and the colours of the season fading from green to rust. This is often a time for reflection and restoration following a hectic year of work and responsibility, an opportunity to take stock and maybe even do some celebrating in the upcoming holiday period. In this edition then, we present four articles which in their own way reflect on key aspects of what we do as therapists.

In our first article *Powerful, seductive and alluring? Money in private practice,* Terry Naughton comprehensively explores the subject, object and symbolism of money in the therapeutic space. Highlighting the dearth of attention paid to the topic of money in therapy training, Terry explores money beyond the apparently simple fee transaction between client and therapist. In particular, Terry charts its relevance in the process of therapy. For professionals, she provides a useful tool to reflect on our relationship with money - The Money Genogram. For clients, the Family Financial Questionnaire provides a means to "explore the historical and emotional significance of money" in their lives and one I'm sure will be very helpful in your work with clients for whom money is a therapeutic theme.

In our second piece, we present part two of James Overholser's article series focussing on the work of William Glasser. In this article, James takes a reflective stance in his questions pertaining to *The Process of Psychotherapy* in his simulated interview with Glasser. The piece ranges broadly, exploring the nature of therapy, advice for new therapists, questions which help clients reflect on their needs and need satisfaction, to matters of personal choice, being accountability for their wellbeing and the nature of Reality Therapy as a means to effect positive, lasting change in the lives of clients. The article ends with a cliff-hanger moment, whetting our appetite for part three of the series which we look forward to presenting in the Spring 2020 edition.

Our third contributor, Brendan O'Shaughnessy offers a practitioner reflection with practical suggestions for working on the topic of communication in couples therapy. Based on nearly 30 years of experience, Brendan describes the impact of communication difficulties on divorce rates, offers insight into traditional approaches used to help couples improve their communication skills and charts an additional approach grounded in his adaptation of the work of Joseph Zinkler (renowned Gestalt couples and family therapist). In the final section of his work, Brendan offers practical suggestions should couples aim to practice nascent communication skills at home. To conclude, he invites therapists to move beyond simply supporting clients with skills development, but to help them "inoculate against future damage and hopefully salve past injuries inflicted by hurtful words".

In our fourth article, the controversy and ongoing discourse between evidence based practice, empirically supported treatments and common factors (those which span all therapeutic modalities) is presented in detail by Daryl Mahon. Though quite a technical article, Daryl creates extremely helpful moments of contact with the extant research literature at the heart of the debate leading us to consider how we as therapists position ourselves within the measure/no-measure continuum. As a useful starting point, Daryl highlights Routine Outcome Monitoring systems which are straight forward to implement in practice and have been demonstrated to be helpful in tracking "client progress, identify those at risk of deterioration, and drop out and those responding to interventions".

We hope that the diversity of thought, presentation, theme and content in our winter edition provide useful insights and plenty of food for thought. But for now, all that remains for this edition is for me to wish you all a very Merry Christmas, Happy Holidays and Compliments of the Winter Season ahead.

Mike Hackett,
Editor, Winter 2019

Committee update:
On behalf of the IJCP Editorial Committee, I would like to extend our most sincere thanks for the wonderful response from members calling for volunteers to join our committee. We are still working through the approval process and will make an announcement to each of our applicants in the next few weeks, with a formal announcement to follow in the editorial of the Spring 2020 edition. We are also heartened by the volume of submissions we have received over the last couple of months from members of the IACP and from our international contributors. Please keep your articles, papers, research coming (and if you do not want to write something in an academic format, please consider submitting a reflective or practitioner perspective based on your experience as a therapist). Contributions from members are the life blood of our journal. Thank you to all of our applicants and contributors.

Academic Article

Powerful, seductive and alluring? Money in private practice

By Terry Naughton

"In the practice, literature and training of psychotherapy, money is one of the most ignored topics and, while it remains unaddressed, it leads to an emotional taboo regarding financial matters"

(Trachtman, 1999; Tudor, 1998)

Introduction

One of the most commonly ignored aspects of psychotherapy in training, literature and practice is money, often resulting in therapists disregarding it (Krueger, 1986; Monger, 1998).This article will explore and outline the relevant literature on money as it relates to counsellors and psychotherapists who work in private practice. The topics of money and therapy, symbolism of money, money as a taboo, lack of training, therapeutic process, fee setting, fee concessions, discomfort charging a fee and ethics will be explored in detail in addition to considerations for changing current practices with regard to how money is dealt with in therapy. Finally, conclusions reflecting on the importance of the role of money in private practice will be outlined.

Money and therapy

Rowe (1997) states that "we recognise money, but we don't know what it means. We alone of all the animal species use money, but we don't understand it. How could we, when money has for us many different meanings?" (p.12). Referring to money, Krueger (1986) observed that it is one of the most emotionally charged elements in present-day life. The only other two competitors for such varied and strong emotions, fantasies and strivings are sex and food. Some of the words used by Trachtman (1999) to describe money are – "powerful", "seductive" and "alluring" (p.275).

Unexamined thoughts and feelings about money can have a great impact on the therapeutic process (Newman, 2005). Money may be associated with a number of themes that are relevant in therapy as suggested by Shapiro (2007), which include boundaries, family of origin, trust, conflict and power. Chan-Brown, Douglass, Halling, Keller and McNabb (2016) highlight the importance of thought and personal history while Barth (2001) believes issues related to self-worth, feelings of deprivation, concerns about envy and competition may also be present. Meaning making is a common theme in therapy and is an important component in the therapeutic process and Tudor (1998) suggests that the meaning of money becomes a central focus of therapy.

Symbolism of money

While it is accepted that money is essential to living, it is also shrouded in symbolic meaning. Geistwhite (2000) notes that money has been symbolically linked to faeces, penis, and breast. Tudor (1998) suggests it represents guilt and dirt. However, Krueger (1991) maintains that money can symbolise self-esteem, esteem of others, potency, power, worldliness, or acceptance and for some clients, money may be viewed as a method to prevent separation and individuation. According to Freud (1913) "money matters are treated by civilised people in the same ways as sexual matters, with the same inconsistency, prudishness and hypocrisy" (p.131). In the literature on this topic, there are references to the similarities between therapy and prostitution. This relates to the acceptance of a fee (often cash) for a service. This is what Schonbar (1967) refers to as the "selling" of a human relationship, however, he later suggests that such concepts may be devised by clients in order to defend against closeness towards the therapist (Schonbar, 1986).

Money as a taboo

In the practice, literature and training of psychotherapy, money is one of the most ignored topics and, while it remains unaddressed, it leads to an emotional taboo regarding financial matters (Trachtman, 1999; Tudor, 1998). "Most of us have learned to talk more easily about sex, yet remain seclusive, embarrassed, or conflicted about discussing money. Money may be the last taboo in our society" (Krueger, 1986, p. vii). This theme of money as taboo runs throughout the literature (Dibella, 1980; Tudor, 1998; Trachtman, 1999) and is confirmed by Shapiro (2007) who states that talking candidly about money is regarded as inappropriate, intrusive and rude, by much of society. Lanza (2001) confirms this, adding that money is a complex of paradoxes.

> *"The teaching is focused on the work of psychotherapy while excluding exploration of the business of doing psychotherapy"*
>
> *(Pasternack, 1988)*

Gans (1992) asserts that while money is a taboo subject, it is also a gateway to the unconscious, which includes primitive affect, features of personality and aspects of orality and anality especially withholding, depletion and greed. Challenging topics that were once combined with money issues were split off from the rest of self. By inviting elements of the unconscious to present themselves, these topics may be reacquainted. This may result in their importance being highlighted in aspects of life other than purely financial.

Lack of training

It is generally agreed that one such subject matter that requires explicit attention in training is the topic of fees. While there is a dearth of literature on the subject of fees in therapy, there is even less on the issue of fees and training (Monger, 1998; Tudor, 1998; Trachtman, 1999; Newman, 2005). Shields (1996) proposes that in the training sphere, without examination of the resistance related to money that may be present for both client and therapist, an opportunity to facilitate the client's experience is lost. Shapiro (2007) notes that therapists have been trained to explore issues of abuse and sexual behaviour, eating disorders, mental illness and drug and alcohol issues, therefore, they can also be trained to sensitively facilitate the significance of money. This is confirmed by Shields (1996) in declaring that the teaching is focused on the work of psychotherapy while excluding exploration of the business of doing psychotherapy. In conducting research with psychotherapists, Power and Pilgrim (1990) discovered that money was generally not discussed in training, while Trachtman (1999) aligns the poor training in fee dynamics with fuelling the money taboo. Pasternack (1988) proposes that training in psychotherapy should include learning and familiarity about fee setting and collection just as much as it does the promotion of other boundaries in the therapy.

Therapeutic process

From a negative viewpoint, money may be a contributory factor in the disruption of the therapeutic relationship (Chodoff, 1996; Holmes, 1998; Lanza 200; Dimen, 2012). One example offered by Power and Pilgrim (1990), is through failure to respond to a client's economic circumstances. However, on a more positive note, Power and Pilgrim (1990) suggest issues of money in therapy (payment of the fee) may become pivotal in the therapeutic process by introducing areas of shame, vulnerability, dependence and self-worth. Zur (2007) believes the fee is essential to the therapeutic boundary separating the relationship in the therapy room from other types of non-professional relationships (friendships or romantic relationships). It is accepted that transference and countertransference are common elements of the therapeutic encounter and when issues of money are being explored or

ignored, these unconscious aspects of relating can be heightened. Holmes (1998) outlines the importance of attending to countertransferential emotions and to use them in the service of therapy.

Fee setting

A common belief among members of the mental health community is that paying for services is a positive element of psychological treatments (Aubry, Hunsley, Josephson & Vito, 2000). Certain authors believe that the fee is a crucial element for effective psychotherapy (Freud, 1913; Power & Pilgrim, 1990) inviting the client to value the process (Herron & Sitowski, 1986). Fee setting invites the therapist to acknowledge the role of the unconscious and any existing emotional factors that may be relevant (Pasternack, 1988).

Newman (2005) outlines possible feelings on behalf of the client that may include guilt, contempt, hostility, seduction and anxiety. Pasternack (1988) reminds us that the modern-day flexible fee policy employed by many therapists originated from a more rigid system proposed by Freud who obeyed a policy of leasing by the hour. His insistence on fee-paying arose from a belief that it reduced the resistances (unnecessary gratitude and obligation) of the patient in therapy (Freud, 1913). He invoked a cancellation policy and believed it was ethical to acknowledge the business aspects of therapy. Separating the psychological meanings from the business aspects of therapy was a strong theme for Freud, but in the present-day, Barth (2001) believes that the two are solidly connected.

Schonbar (1967) outlines a therapeutic attitude toward fee setting and the avoidance of a rigid fee policy. A flexible approach encourages the client to engage in the treatment process and invite unconscious conflicts to the fore. Schonbar (1967) proposes invitation of an open discussion regarding missed appointments and aspects of non-payment rather than invoking an automatic charge on an administrative basis. A flexible approach aids productive therapeutic exploration and assists the therapist in meeting their own countertransferential issues, should they arise (Schonbar, 1967). A study conducted by Clark and Kimberly (2014) found that the fee paid for therapy has no impact on a client's attendance. While conducting a review of the literature on the effect of fees on psychotherapy, Herron and Sitowski (2014) discovered that the therapeutic value of fee-paying has not been theoretically proven.

> *"If fees are modified during the course of therapy, the therapist should remain alert to transference and countertransferential elements of the therapeutic process"*
>
> *(Pasternack, 1988)*

Fee concessions

Pasternack (1988) suggests that a reduced fee may represent collusion on behalf of the therapist in an attempt to foster dependency. This may result in the client feeling "special" or, alternatively, it may generate feelings of indebtedness to the therapist. Unconsciously, this may encourage a lack of progression within therapy and could lead to the client perceiving the reduced fee as a form of seduction. Pasternack (1988) believes this is difficult to detect but is essential to uncover in order to promote a positive therapeutic environment. If fees are modified during the course of therapy, the therapist should remain alert to transference and countertransferential elements of the therapeutic process (Pasternack, 1988). Newly qualified therapists can often feel conflicted about charging for therapy, occasionally accompanied by feelings of guilt about the quality of the service they provide. The introduction of a reduced fee can often assist in lowering performance pressure on the fledgling therapist (Myers, 2008).

Discomfort charging a fee

Knapp and VandeCreek (2008) state "Most psychotherapists are reluctant businesspersons. They consider the business side of their profession to be a necessary evil that allows them to do what they really love: psychotherapy" (p.613). Lanza (2001) proposes that many clients and therapists feel a discomfort discussing fees and suggests this may emanate from the Protestant ethic of praising hard work but never enjoying the fruits of the labour. However, according to Geistwhite (2000) the process of fee setting, despite its discomfort, is a precursor for all future discussion of challenging topics in therapy.

Ethics

From an ethical values viewpoint, focusing on the business element of a therapeutic practice (including setting fees) is essential (Knapp & VandeCreek, 2008). In its 2016 Ethical Principles of Psychologists and Code of Conduct, the American Psychological Association (APA) expects therapists to accurately represent their fees (APA, 2016). The British Association for

Counselling and Psychotherapy (BACP, 2018) suggests that when contracting with clients, therapists should inform them of the terms on which their services will be provided. The Irish Association for Counselling and Psychotherapy Code of Ethics and Practice (2018) refers to making a contract with a client and to "include issues such as availability, fees, and cancelled appointments" (Section 2.3(b)). This encourages the therapist to be open about fees and any extra costs that may arise. However, Shapiro and Ginzberg (2006) suggest that limited guidelines in codes of ethics result in fee setting being left to the discretion of the therapist.

Considerations for change

Informed by the research outlined above, as therapists, I suggest we consider changes in how we reflect on and approach money in private practice.

One of the gaps identified in the research is the lack of business training for therapists (Tudor, 1998; Power & Pilgrim, 1990; Monger, 1998; Newman, 2005; Shapiro, 2007). Considering the therapists' beginnings is at the training stage, I suggest the provision of enhanced training in the area of the business of therapy. The identified research highlights the need for solid, financial arrangements to be put in place for all therapists. If this is undertaken the therapist provides the "safe therapeutic frame that reinforces professionalism and predictability" (Apostolopoulou, 2013, p. 315). This could begin in training colleges and institutions.

Fee setting (along with fee concessions and discomfort charging a fee) has been identified as a strong theme in the literature and every therapist who begins in private practice faces this task.

> "Discussion with peers, supervision, personal therapy, training or workshops are fora that may be useful while simultaneously helping to dispel the taboo of filthy money"
>
> *(Tudor, 1998).*

Therapists who may be hesitant about setting a fair fee structure or who feel unsure about the therapy they provide may undermine the value of the therapeutic offering (Pasternack, 1988). As has been outlined, private practice is a business. I would suggest that prior to beginning this process, the therapist reflect on their own personal relationship with money. This may highlight values held by the therapist about money and invite reflection on the place of money in their life, past and present. Unconscious sabotaging beliefs may be uncovered. Insight into the role their personality style plays in their relationship with money may be achieved. A tool similar to the money genogram may be useful in this regard. (See Appendix A). I would strongly recommend that therapists avail of any platform that may provide an opportunity to discuss or explore money issues. Discussion with peers, supervision, personal therapy, training or workshops are fora that may be useful while simultaneously helping to dispel the taboo of filthy money (Tudor, 1998).

An ethical stance suggests that a solid payment policy should be considered, supplying clients with accurate information about the costs of starting or continuing therapy. Bearing in mind that a money taboo has a negative effect on the therapeutic encounter, the research identified the importance of exploring the meaning of money and its impact on both transference and countertransference. Inviting space and time for the client to openly discuss their thoughts, feelings, attitudes and behaviours about money may be a helpful offering. A tool to explore the historical and emotional significance of money in the life of the client may be useful. Once such tool is the Family Financial Questionnaire (Shapiro, 2007) (See Appendix B).

Therapists should be wary of unusual fee arrangements suggested by clients, noting that comments and behaviour related to payments are often not just administrative details. Broadening a focus that incorporates all money matters as "royal roads" to insight, may alert the therapist to consider this as material for processing in therapy. This may open a view to the client's internal dynamics and perhaps unconscious material and pave the way for exploration of negative adaptations and wider impacts on life.

Conclusion

Money is needed for everyday life and is also "a metaphorical currency for power, control, acknowledgement, self-worth, competence, caring, security, commitment, and feeling loved and accepted" (Shapiro, 2007, p. 290). As outlined, money has an emotional as well as a financial component to it. Miller (2007) suggests that the therapist never underestimate the complexity of setting a fee that is comfortable, achievable, reasonable and ethical. Lanza (2001) proposes that it is not greedy to seek compensation for the provision of therapeutic services, but rather a form of self-respect.

As a business, it is helpful for practitioners to acknowledge the tension between being a therapist and a businessperson, between altruism and professionalism (Knapp & VandeCreek, 2008). By acknowledging that tension, we offer our clients an opportunity to explore their underlying values, beliefs, thoughts and feelings as well (Shapiro & Ginzberg, 2006). Cooper (2017) asserts that movement within therapy can be facilitated by working creatively and therapeutically with money. Who knows, in the process, we may even "uncover buried treasure – a richer understanding of the self" (Shapiro & Ginzberg, 2006, p. 493).

Terry Naughton

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Appendices

Appendix A – The Money Genogram

Meaning and function of money

1. What does money mean to you?
2. What does it mean to have financial self-discipline? What is positive about it? What is negative about it? How do you feel when you exercise financial self-discipline?
3. What does it mean to overspend?
4. What does it mean to underspend?
5. On what terms do you tend to over or underspend money?
6. How do you feel when you overspend and underspend? Identify all feelings, those on the surface and underneath.
7. What are your overt and covert motivations for over- or under- spending or being self-disciplined?
8. What are your financial priorities?
9. In what ways do you agree or disagree on your financial priorities?
10. Who has control over the money in your relationship? What are the rules you have about how to manage your money?
11. How would you like to change some of the rules about the two items above?

Money genogram

1. What was your mother's role concerning finances? What was your father's role? How is your role like either of your parent's role?
2. As a child, did you think you were rich, poor, or middle-class? How did that feeling affect your perception of money now?
3. What were the money concerns or worries you experienced in your family? What lessons did you learn from them? Have those lessons altered how you deal with money now?
4. What big financial successes occurred in your family? What lessons did you learn? How have those lessons altered the way you deal with money now?
5. What was your family's greatest money fear or worry? Why?
6. In thinking about what your family did with money or could have done with money, what makes you the most uncomfortable? What gives you the greatest pleasure?
7. Were your parents well matched in money values? On what did they have different values?
8. Did your parents maintain separate checking and saving accounts? How did they decide which bills were to be paid out of which account?
9. How often did your parents talk about money? What were their conversations like?
10. Who paid most of the common household bills? How was it decided which parent should have the duty?
11. When there was a conflict about money, how was it resolved? Was there a pattern in either the conflict or who won?

Adapted from -

Mumford, D. J., & Weeks, G. R. (2003). The money genogram. *Journal of Family Psychotherapy*, *14*(3), 33-44.

Appendix B – Family Financial Questionnaire

The following questions can serve as a guide to exploring the history and emotional significance of money for a client.

(1) What are your earliest memories of money in your family? What is your best and worst memory regarding money? What feelings do these memories generate? Was money viewed as good, bad, scary, dirty, or neutral for you as a child? Did anyone help you to understand these feelings as a child? Were there any family stories about money?

(2) How did your parents talk about money between themselves and with the children? Was it easy to talk about, or was it treated as a secret? What kind of tone was used in the discussions? Did your parents fight about money, and if so, how?

(3) Did your parents agree about how to deal with money? Who was in charge of spending, and who was in charge of saving? Did working, or earning the bigger portion of the income, connect to control over money?

(4) How did your mother think and feel about, and deal with, money? How did her parents think and feel about, and deal with, money? Did your mother enjoy working (or staying home)? How did you know and what impact has this had on you? Repeat using father. How well off did you feel growing up? How did that change over the course of your growing up, if at all?

(5) What is your first memory of having an argument or disagreement about money in your family? What were your feelings regarding arguments about money, and how has this impacted you?

(6) If you have siblings, were different genders or different ages treated differently in regard to money? How are your attitudes and feelings about money different from or the same as those of your siblings?

(7) What is your first memory of making money of your own? How much control did you have over any money you made or received as a gift?

(8) Where else did you get messages or information about money while growing up? Other relatives, religion, peers, TV, culture? How did these messages influence you?

(9) What financial expectations did your parents and grandparents have of you? How was this communicated to you? What financial expectations do you have of your parents or grandparents?

(10) What would you like to do differently from your parents regarding money in your relationship? What would you like to do the same?

Adapted from -

Shapiro, M. (2007). Money: A therapeutic tool for couples therapy. *Family Process*, *46*(3) p. 280-281.

Academic Article

A simulated interview with William Glasser: Part 2 – The Process of Psychotherapy

By James C. Overholser, Ph.D., ABPP

Introduction

Reality Therapy provides a framework that can encourage choice, responsibility, and plans for change. The therapist relies on a supportive bond to push the client for immediate and visible change in daily actions and to move clients closer toward their life goals. The therapist makes a strong and persistent focus on helping clients to make wise choices, whilst avoiding any discussion of past events or excuses.

Despite a fairly directive style, reality therapy remains compatible with the Socratic method and guided discovery. Throughout sessions, the therapist encourages clients to identify their own major life goals and begin making daily changes in behavior that helps them to move toward accomplishing those goals. The therapist brings an action-focused view, both to the goals of each session as well as the language used to describe various symptoms. By changing passive nouns into active verbs, clients may be forced to accept personal responsibility for their own symptomatic behavior. These issues are discussed in a simulated interview with Dr. William Glasser (WG) led by James C. Overholser (JCO).

JCO: Thank you for meeting with me. I wish to ask you a few more questions.

WG: "Oh, certainly" (Glasser in Gough, 1987, p. 662). "Sit down and make yourself comfortable" (Glasser, 1976i, p. 654).

JCO: I respect the central importance of the therapeutic relationship. Do you agree that therapists provide an essential supportive relationship?

WG: "Yes, but you do a lot more as well. You try to prevent problems from happening in the first place" (Glasser, 2000, p. 53). "It is incumbent on counselors to form good relationships with all clients" (Glasser, 1998, p. 132). "We must be warm, personal, and friendly" (Glasser, 1976h, p. 53). "Warmth, understanding, and concern are the cornerstones of effective treatment" (Glasser & Zunin, 1979, p. 316).

JCO: I thought the key to Reality Therapy was a strong push for realistic changes. So how important is the therapeutic relationship?

WG: "The relationship between the therapist and the client is very important and the type of counseling only plays 15%" (Glasser, 2016, p. 38). "It is important that I be warm and uncritical" (Glasser, 1996, p. 174). "An important distinguishing trait of a good psychotherapist is his ability to accept patients uncritically and understand their behavior" (Glasser, 1965, p. 28). "Patients with emotional problems need someone who will be warm and personal with them" (Glasser, 1976e, p. 349). "The therapist must be able to become emotionally involved with each patient" (Glasser, 1965, p. 28). "We must become as involved as possible with his strong points, his interests, his hopes" (Glasser, 1964, p.140).

JCO: In your view, *how* does the therapeutic relationship help?

WG: "Involvement is the foundation of therapy" (Glasser, 1976h, p. 53). "Involvement with at least one successful person is a requirement for growing up successfully, maintaining success, or changing from failure to success" (Glasser, 1975, p. 71). "Each of us wants to be able to say, 'Someone listens to me; someone thinks that what I have to say is important" (Glasser in Gough, 1987, p. 658). "People who aren't able to say, 'I'm at least a little bit important' in some situation will not work hard to preserve or improve that situation" (Glasser in Brandt, 1988, p. 40). "The therapist's problem is to provide enough involvement to help the patient develop confidence to make new, deep, lasting involvement of his own" (Glasser, 1976h, pp. 53-54).

JCO: What advice would you give to a novice psychotherapist?

WG: "Try very hard not to insert our beliefs into the process of counseling" (Glasser, 2016, p. 6). "Help the patient to evaluate his own behavior … Avoid making this evaluation for him … If you usurp his decision, the patient loses responsibility for his behavior" (Glasser, 1976e, p. 350). "The therapist continually asks clients to evaluate the effectiveness of what they are choosing to do" (Glasser, 2000, p. 227). "The crux of the theory is personal responsibility for one's own behavior" (Glasser & Zunin, 1979, p. 302).

JCO: Is your therapy style compatible with the Socratic method of psychotherapy?

WG: "Yes that's a fair statement" (Glasser in Evans, 1982, p. 461). "It is a kind of Socratic questioning"

> "I don't promise to produce happiness or alleviate misery"
>
> *(Glasser, 1964, p. 138)*

(Glasser, 1976b, p. 47). "The therapist does not judge the behavior; he leads the patient to evaluate his own behavior" (Glasser, 1975, p. 85). "Unless they judge their own behavior, they will not change" (Glasser, 1976d, p. 99). "I ask questions designed to get them to evaluate their behavior against reality" (Glasser, 1976b, p. 42).

JCO: Can you give me a few examples of questions you might ask your clients?

WG: "Of course" (Glasser in Gough, 1987, p. 662). "The basic Reality Therapy question, 'is what you are doing (or choosing to do) getting you what you want?'" (Glasser, 1989a, pp. 14-15). "Is what you are doing helping you?" … "Is it the kind of thing that's going to make life better for you in the future" … "Are you doing what will help you to fulfill your needs" (Glasser, 1980, p. 51) … "Does your present behavior have a reasonable chance of getting you what you want now and will it take you in the direction you want to go?" (Glasser, 1989b, p. 5) … "What could you choose to do tomorrow that would be better than today?" (Glasser, 2000, p. 135).

JCO: These are great questions. Are there some questions that are most helpful for motivating clients to change?

WG: "The therapist continually asks clients to evaluate the effectiveness of what they are choosing to do" (Glasser, 2000, p. 227). "The important control-theory question 'is the criticizing and misery I am now choosing helping me to get what I want?'" (Glasser, 1984, p. 171). "How is this choice to depress going to help me deal with this situation? If it isn't helping me, can I choose something better?" (Glasser, 1998, p. 78). "How long do you want to choose to be miserable?" (Glasser, 2000, p. 36).

JCO: It sounds like you're saying that therapists should encourage clients to share their burdens and express their misery in session.

WG: "I know it does, but it's really not" (Glasser in Gough, 1987, p. 659). "I don't promise to produce happiness or alleviate misery" (Glasser, 1964, p. 138). "It is unwise to talk at length about a patient's problems or his misery" (Glasser, 1975, p. 77). "Long discussions about the patient's problems can be a common and serious error in psychotherapy" (Glasser, 1976h, p. 54).

JCO: Why?

WG: "It is tempting to listen to his complaints because they seem so urgent. Doing so may reduce his pain and make him feel better for awhile as he basks in the attention he receives" (Glasser, 1976h, p. 55). "Talking at length about a patient's problems and his feelings about them focuses upon his self-involvement and consequently gives his failure value" (Glasser, 1975, p. 77). "Our job is not to lessen the pain of irresponsible actions, but to increase the patient's strength so that he can bear the necessary pain of a full life as well as enjoy the rewards of a deeply responsible existence" (Glasser, 1965, p. 72).

JCO: If you do not spend time listening to a client's complaints, where do you go instead?

WG: "Don't talk so much about how people feel" (Glasser, 1982,

p. 461). "Get to the real problem, what the client is choosing to do now" (Glasser, 1998, p. 117). "We choose what we do or what we do not do" (Glasser, 2004, p. 340). "We choose most of the misery we feel" (Glasser, 1984, p. 2).

JCO: Are you saying that people choose to become depressed? That attitude would upset a lot of people.

WG: "That's an important question" (Glasser, 2000, p. 54). "The world never causes us to do what we do; rather, we behave in certain ways to get what we want" (Glasser, 1985, p. 242). "If you don't believe me all you have to do is think back to a time in your life when you really had a hard time, and you'll find that when you 'recovered' it wasn't because the world had suddenly become a better place, it was because you made a better choice" (Glasser in Brandt, 1988, p. 44). "What happened is done and people have to satisfy their needs now" (Glasser in Nystul & Shaughnessey, 1995, p. 441).

JCO: But some people are stuck in a bad situation.

WG: "Excuse me if I don't agree with you" (Glasser, 2002, p. 73). "Nothing we do is caused by what happens outside us" (Glasser, 1984, p. 1). "How you feel is not controlled by others or events" (Glasser, 2013, p. 6). "One of the most difficult lessons to master … is to learn not to label something 'bad' just because it is different from what we want" (Glasser, 1984, p. 81). "Every client, at the time that therapy begins, is choosing some sort of painful, self destructive behavior in a misguided or misunderstood attempt to regain control over a poorly controlled, need-frustrated life" (Glasser, 1989a, p. 5). "We choose everything we do, including the misery we feel" (Glasser, 1998, p. 3). "Regardless of how we *feel*, we always have some control over what we *do*" (Glasser, 1984, p. 45).

> "We almost always have choices, and the better the choice, the more we will be in charge of our lives"
>
> *(Glasser, 2013, p. 2)*

JCO: Why would someone choose to be miserable?

WG: "Pretty much every behavior that is important to you is chosen" (Glasser in Onedera & Greenwalt, 2007, p. 82). "We almost always have choices, and the better the choice, the more we will be in charge of our lives" (Glasser, 2013, p. 2). "What we choose is the best choice at the time we choose it" (Glasser, 2000, p. 2). "If I choose all I do, maybe I can choose to do something better" (Glasser, 2000, p. 26).

JCO: Does that change how to treat depression? I have been helping a depressed client, and sometimes he just feels better by sharing his concerns with me in session.

WG: "A major purpose of all psychological symptoms is to get sympathy and attention" (Glasser, 2000, p. 72). "If we ask them how they feel, it seems that our listening recognizes, and to them justifies, how they feel" (Glasser, 1980, p. 51). "He had been getting his failure reinforced and his pain temporarily reduced with each new complaint that was heard" (Glasser, 1975, p. 78). "It is important that depressed patients do not get sympathy because sympathy emphasizes their worthlessness and depresses them even more" (Glasser, 1965, p. 183). "The worst thing anyone can do for a depressed friend is to let him whine excessively about his troubles" (Glasser, 1975, p. 78).

JCO: So you feel that clients choose to become depressed?

WG: "What we usually call psychological problems are, in fact, the ways we choose to behave when we find it particularly difficult to satisfy our needs" (Glasser, 1996, p. 172). "We choose what we do or what we do not do" (Glasser in Brandt, 1988, p. 43). "Once you accept that misery is a choice, you will look for better choices to replace it" (Glasser, 1984, p. 56). "Many times in life, when we are miserable it is because we continue to blame others for our misery or try to control others" (Glasser, 1998, p. 19). "Remember, we can only control our own behavior, so you should talk solely about what you are willing to do, not what you want the other to do" (Glasser, 1998, p. 98).

JCO: So action takes priority over emotion?

WG: "Absolutely" (Glasser in Onedera & Greenwalt, 2007, p. 82). "Changing behavior leads quickly to a change in attitude" (Glasser, 1965, p. 34). "People often avoid facing their present behavior by emphasizing how they feel rather than what they are doing" (Glasser, 1976h, p. 56). "The most common misery we choose is depressing, but we can also choose to withdraw, complain, go crazy, drink, or use drugs" (Glasser, 1993, p. 109). "We do not use the adjective depressed, we do not use the noun depression. We always use the verb form to describe behavior" (Glasser, 1989, p. 8).

JCO: Why does it matter to make this change of phrasing?

WG: "By transforming these static

words into actions that more accurately reflect choices, I hope to imply that these behaviors are subject to change" (Glasser, 2013, p. 3). "If I say I am depressing or I am choosing to depress, it is very hard for me to think that this is happening to me. I have to begin to think that I have a choice and that maybe I could do something better" (Glasser, 1989, p. 9). "If we choose to depress, we can also choose to stop depressing" (Glasser, 2000, p. 26).

JCO: So choice is the key?

WG: "I now believe that we choose essentially all we do" (Glasser, 2000, p. 225). "Emotions are chosen" (Glasser, 1976a, p. 18). "We can gain a great deal of control by learning that we choose to depress" (Glasser, 1984, p. 81).

JCO: But some of my clients have become depressed over the disruptive events in their lives.

WG: "I hate to nitpick, Jim, but …" (Glasser, 2000, p. 43) "this is completely untrue" (Glasser in Harmon, 1993, p. 45). "There's no way to live your life without problems" (Glasser in Brandt, 1988, p. 44). "While we choose all of our long-term feelings, painful as well as pleasurable, … we do not choose the immediate short-lived feelings" (Glasser, 1984, p. 71). "When we depress, we believe we are the victims of a feeling over which we have no control" (Glasser, 1998, p. 70). "To check out my claim that depressing is a choice, force yourself to make a different choice for a short time, for at least an hour" (Glasser, 1998, p. 83).

JCO: I often tell my clients that if things are not getting better for them, we want to try something different, not just keep doing more of the same. Would you agree?

> "Lack of success, more than any other one thing, contributes to nonmotivation"
>
> *(Glasser, 1971, p. 18)*

WG: "Absolutely" (Glasser in Brandt, 1988, p. 40). "We can choose to do better with our lives–providing we are willing to make the effort to do so" (Glasser, 1989a, p. 2).

JCO: One of my clients seems to be stuck in his bad habits. How can I get him unstuck?

WG: "Asking him for his plan tells him that he should have a plan, or at least start thinking of one" (Glasser, 1965, p. 46). "What are you planning to do today?" (Glasser, 1998, p. 78). "Successful people tend to make a plan and channel their efforts into that plan" (Glasser, 1976c, p. 70). "It is best that plans be discussed, written out, and checked off" (Glasser, 1996, p. 174).

JCO: I rely on shaping, trying to help clients start small and build up to bigger changes. Does that fit your style?

WG: "Oh, certainly" (Glasser in Gough, 1987, p. 662). "Make sure the patient commits himself at first to a small action - one that he can accept easily and likely can succeed at" (Glasser, 1976e, p. 350). "Never make a plan that attempts too much, because it will usually fail and reinforce the already present failure. A failing person needs success, and he needs small, individually successful steps to gain it" (Glasser, 1975, p. 89). "Lack of success, more than any other one thing, contributes to nonmotivation" (Glasser, 1971, p. 18).

JCO: As a therapist, where is your focus?

WG: "The essence of Reality Therapy is problem solving" (Glasser & Zunin, 1979, p. 328). "Our job is to help the patient help himself to fulfill his needs right now" (Glasser, 1974, p. 190). "The concept of choice becomes crucial when making plans for the future" (Glasser, 1990, p. 584).

JCO: *How* do we help clients fulfill their needs?

WG: "Our job as therapists is to teach clients how to act and think more effectively so they can better satisfy their needs" (Glasser, 2000, p. 67). "I believe people choose the behavior that has led them into therapy because it is always their best effort to deal with a present, unsatisfying relationship--or, worse, no relationships at all" (Glasser, 2000, p. 22). "Good or bad, everything we do is our best choice at that moment" (Glasser, 1984, p. 3).

JCO: I have a client who rarely completes his therapeutic task between sessions. How do I handle it?

WG: "Accept no excuses" (Glasser, 1975 p. 92). "Get to the real problem, what the client is choosing to do now" (Glasser, 1998, p. 117). "The therapist must say to the patient, 'If you are not going to do it, say so, but don't say you are and then give excuses when you fail'" (Glasser, 1975, p. 94). "In a world where excuses are readily accepted, many people hesitate to do their best. In reality therapy, when there is commitment to a plan, there is no excuse for not following through … Maybe we have to drop this plan and figure out a new one? But under no circumstances will the therapist

accept an excuse" (Glasser, 1980, p. 54).

JCO: I agree. I am rather intolerant of excuses, and I have heard quite a few, but flat out rejecting an excuse may damage the rapport I have with the person.

WG: "It might" (Glasser, 2000, p. 191). "We simply ask, 'Are you still going to try to fulfill the commitment?' (Glasser, 1975, p. 93). "Excuses let people off the hook; they provide temporary relief, but eventually lead to more failure and a failure identity" (Glasser, 1975, p. 94). "The therapist who accepts excuses, or allows the patient to blame his present unhappiness on a parent or an emotional disturbance can usually make his patient feel good temporarily at the price of evading responsibility" (Glasser, 1973, p. 579). "The accepting of an excuse is saying to the person, 'I accept your inadequacy, I accept your misery, I accept your inability'" (Glasser, 1980, p. 54).

JCO: I have a few more things I'd like to discuss.

WG: "Wait a second. Let's stop here" (Glasser, 1976j, p. 467).

JCO: Sure. Maybe we can schedule one more time to talk?

WG: "I am more than happy to" (Glasser in Onedera & Greenwalt, 2007). I'll see you again on Monday" (Glasser, 1976f, p. 669).

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Reflective Article

Can't we just talk to each other?
Supporting Couples to Improve their Communication

By Brendan O'Shaughnessy

Introduction

Pat: *I don't know many times I have tried to explain to Chris how I feel. When I can't get through, I find myself getting angry and, to my shame, say things that I know will hurt just to get a reaction.*

Chris: *I try to listen but feel blamed from the off. When I try to defend myself, Pat gets angry and I just shut down. Pat will say hurtful to me and even though I know I will regret it later, shout and hurt back.*

Pat & Chris: *We just don't seem to be able to get out of this pattern and it is getting worse. If we can't improve our communication, this relationship will not last.*

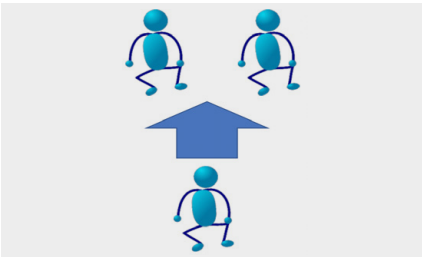
As a therapist working with couples for 28 years, a constant theme in the work is that of communication. Often, this is explicitly named as the presenting issue as in the example above but can also become the focus of therapy after an immediate crisis is dealt with. So, how do we help couples with the challenge of improving how they communicate? In this article, I will propose that helping them to communicate with each other, might be an alternative to talking at them or with them.

Prevalence of communications issues

At a time when we have more information and means of interacting with each other, the prevalence of communication issues seems to be increasing. For example, in 2013, lifestyle website *YourTango.com* polled 100 mental health professionals and found that communication problems were cited as the most common factor that leads to divorce (65 percent), followed by couples' inability to resolve conflict (43 percent). So, when couples come to us for support with communication, what can we do to help?

For couples therapists, traditional approaches include activities such as; normalising, education and modelling.

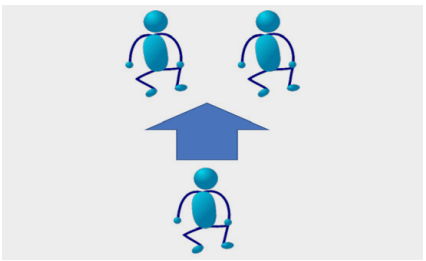
Normalising



Every couple is unique, but it is nice for them to hear that other couples are struggling with the same issues. At some point in the initial session, it is important to let the couple know

that while their issues are unique to them, many other (if not all) couples, share various communication difficulties.

Education

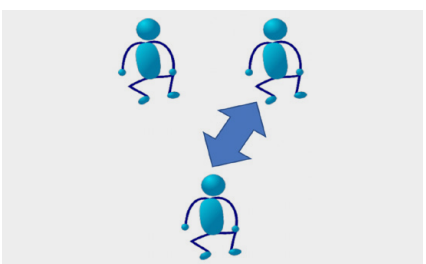


Having normalised the couples experience, another step may be to educate them on the various styles of communications and the impact these have on their relationship. John Gottman, Professor Emeritus from the University of Washington, a researcher focussing on couples' behaviours for over 40 years, has suggested that there are four types of communication problems that can lead to divorce:

- Criticism of partners personality
- Contempt
- Defensiveness
- Stonewalling (the refusal to communicate at all)

More information on these communication problems can be found here; http://www.acouplesplace.com/Gottmans_Four_Horsemen_are_Divorce_Predictors.html. Explaining these concepts and raising awareness of the complexities of communications can become a steppingstone to new opportunities.

Modelling



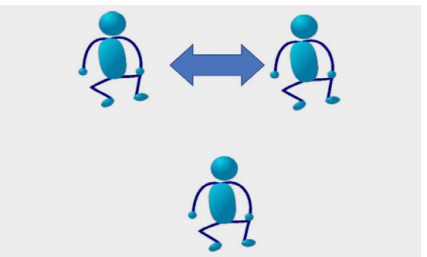
Another possible approach is to model a more respectful style of communication. Doing so with one of the couple and having the other observe how this results in more positive engagement, can raise awareness and offer alternatives to the way they have been communicating with each other.

Issues with the above approaches

Reflecting on the images accompanying the approaches above, we notice however that;

- The therapist is working hard (arrow direction in the normalising condition).
- The couple are being talked to and at (arrow direction in the educating condition).
- The couple are not communicating with each other (the absence of an arrow between the members of the couple).

An additional approach



Some time ago, I was lucky enough to receive training from renowned Gestalt therapist and author Joseph Zinkler. In that programme, Zinkler introduced the concept of helping families and couples to talk to each other and means by which therapists can actively encourage and support them this activity (see diagram, left). As a result, and over man years, couples themselves have helped me to develop a way of doing this that works for them and me. The following are the main steps involved.

1. **Introducing the concept:** When a couple identifies that their interpersonal communication is a relationship difficulty, I tentatively introduce a tool for them to improve this aspect of their relationship, one which they can adopt and adapt as a basic model to suit themselves. If interested, I will explain that there is a structure to improving communication which will feel awkward in the beginning and encourage them to *fake it 'til they make it*, until they learn how to use the structure on their own. Often, initial awkwardness stems from their feeling self-conscious when using this method in front of me, but that is OK and will wear off in time.

2. **Structure and seating:** The structure involves setting up a system of deliberately communicating with each other and to do so in a structured way. The couple is invited to move their chairs around to face each other. This often involves a lot of giggling to hide the nervousness of having to look at each other.

3. **Body language and eye contact:** I sometimes tell the story of the client who had their legs thrown out in front of them, their arm over the back of the chair, staring up at the ceiling and saying "I am listening" before noting the importance of looking at each other in the eye. Raising awareness that our communication is not just verbal and for each of them to take responsibility for their non-verbal messages.

4. **Listening and talking:** The idea is for one person to talk and for the other to listen. The person who is talking is invited to help the other person understand what is going on

for them, without blaming. This is highlighted as one of the more difficult parts of this exercise. It is explained that conversations that start with "I feel bad because you …" are going to lose the listener in defensiveness after the first sentence. For the person who is listening, their challenge is to be curious about what the other person is telling them about themselves while trying to avoid thinking about answers, solutions, becoming defensive, etc.

5. **Feedback:** The person talking, has 5 to 10 minutes to help the listener to understand them better. Then the listener is invited to tell them what they heard. No interpretations, no analysis, just what they heard. This can vary between being an affirming experience to hear your partner "get you" to highlighting just how difficult their communication habits have become. Mainly (often due to defensiveness), the listener will struggle to remember what was said or miss the important emotional content.

6. **Role of the therapist:** I explain in the beginning that my role is to support, observe and keep the structure in the beginning. As they become more accustomed to communicating in this new way, I may bring to their awareness the habits they exibit that inhibit effective interpersonal communication. Zinkler says it best when describing the next step as having "the family talk to each other, promising them that they can turn to us for help or that we will (respectfully) interrupt them to tell them of our observations of their process" (1994, p. xxix). A good example of this is a vague way of talking e.g. *one would feel, if they were in my position, that my life could be in some ways more something*. Without the choice of complaining, the speaker may find it difficult to express how they feel. If one of the couple is struggling, I will support them with questions to elicit what they are trying to express or name their difficulty in listening to what is being said. In the beginning, I find my main role is to remind the speaker that they are not allowed to blame if they want to be heard and understood.

When couples come to us requesting support with their interpersonal communication, we have a deeper responsibility than simply supporting them to talk and listen to each other.

7. **Topics:** After complaining in the beginning of therapy, that their partner never listens to them, one or both of the couple may struggle to know what to talk about when presented with the opportunity, because of not being able to blame. Others may start to talk about very deep feelings too soon. Supporting the couple to choose topics that are not too frivolous or too deep is one of the key roles of the therapist at this point.

8. **Results:** Couples have reported that having to concentrate on what they are communicating to each other and actually listening, is an exhausting but very rewarding experience. The encounter of being heard, understood, and having this fed back is often described as *feeling amazing*. It reminds couples of when they first met and shared every thought. Another common theme is that the issues they originally brought to counselling now, do not appear to be that serious, or the cause of disharmony, now that they have found a way to reconnected with each other.

What could possibly go wrong?
Members of a couple often move at different speeds. This can partly be mediated by how strained their communication has become and how hurt each remains from the legacy of past arguments. Unsurprisingly, it is tempting for couples to try this at home, especially if they have had a good experience in-session. However, the following are some of the pitfalls, that need to be mentioned before trying this at home:

i. **Who will organise it?** On several occasions, couples have left the therapeutic space to try this at home, only to report back that each was waiting for the other to initiate it. It seems this is a power play to establish whether the other person is interested. I have learned to work with couples to agree who will be responsible and how they will share this responsibility between them as a precursor to home trial.

ii. **Where and when?** Given the busy lives that people lead, finding the time and place to have these conversations can be difficult. It is unwise to embark on this emotional exercise when one or both is tired after a long day.

However, even the effort required to make time for each other is a building block in recovering the experience of joy in the relationship.

iii. **Interruptions:** Texts, calls, WhatsApp messages, Instagram and Facebook post notifications and emails pings can not only interrupt these communications sessions but can lead to further rancour if they are one of the sources of discontent in the first place. The prospect of intrusion by children, family, neighbours, friends needs to be considered by the couple and how these will be dealt with in advance of trying this at home.

iv. **Length of sessions and sharing of time:** After years to not being heard, the temptation for a person prone to *flooding* is to grab the opportunity of being heard and hang on to it for as long as possible. For someone prone to *stonewall*, this can be an overwhelming experience and they will retreat into their safe place more than ever. Agreeing in advance that these sessions will not last for more than 30 to 40 minutes with each person getting time to speak and listen is an important convention to establish.

v. **Planning communication sounds too structured?** I have heard couples express their reservations that planning and working towards a style of communications sound like it is not spontaneous and free. However, it is offered as a tool for them to use when they have something important to share and they don't want it to result in yet another argument. This also has a secondary benefit in that it provides a release of tensions and misunderstandings that can accumulate over time and result in full-blown arguments where legacy resentments and frustrations are aired. As the great philosopher, Roy Keane once said "Fail to prepare, prepare to fail" (Keane, 2002). Therefore, giving themselves the best chance for this technique to take hold by being well prepared and agreeing to the terms of the arrangement is important.

vi. **But it should not be this hard:** I tell couples that *happy ever after* is a myth and that relationships take work, even to the point of the mundane act of planning how not to fail at communicating. As M. Scott Peck observed the "problem is that the experience of falling in love is invariably temporary" (Peck, 1978, pg. 67). Of course, seeing your partner working with you to improve your relationship is greatly rewarding and can server as a confirmation that they do in fact love you.

Conclusion

We can all operate on autopilot when communicating. Much of our effort is spent on trying to persuade, cajole, manipulate or influence others to get what we want. When this is affected in an intimate relationship, day-after-day, it can result in neither person listening and the death of effective interpersonal communication. When this happens, intimate connections are severed, and each partner can feel lost and bereft. Knowing each other well enough to know how to trigger each other's vulnerabilities is then a way couples develop as a way to remain connected in the absence of intimacy. It generates a connection, but at an enormous cost to the relationship.

When couples come to us requesting support with their interpersonal communication, we have a deeper responsibility than simply supporting them to talk and listen to each other. It is an opportunity for them to inoculate against future damage and hopefully salve past injuries inflicted by hurtful words and deeds. Words have the ability to hurt and heal. Really listening to the one you love has no disadvantages.

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Academic Article

A World of Dichotomies: Empirically Supported Treatments or the Common Factors?

Utilising Evidence Based Practice and Practice Based Evidence to mediate this Discourse and Improve Practitioner Outcomes.

By Daryl Mahon

Introduction

Psychotherapeutic discourse is often filled with provocative nomenclature and split into false dichotomies. The aim of the current paper is to review one such debate regarding those advocating for the utilisation of diagnostic specific Empirically Supported Treatments (EST) and on the other side, proponents of the Common Factors (CF) approach to therapy who offer up a counter argument. This paper investigates current discourses by illuminating these dichotomies based on a critical review of current literature. Furthermore, an integrative framework will be provided as a method to mediate this discourse based on current literature and within the operationalisation of Evidence Based Practice (EBP), as the framework was originally designed to be utilised. By introducing research at the cutting edge of practice, this paper will align evidence based practice and practice based evidence as two sides of the one coin, and within an integrative practitioner developmental framework.

Empirically Supported Treatments

The American Psychological Association describes evidence-based practice "as the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (APA, 2005). Originally developed within the medical paradigm (Sacket et al, 1996) in order to improve outcomes. Nevertheless, in recent times EBP has come to be understood as a psychosocial intervention that is supported by evidence of utility in the literature. According to Laska, Gurman and Wampold (2014) in a recent survey of clinical psychology graduate students, the majority identified EBP as synonymous with empirically supported treatments; this understanding was also prevalent with practitioners (Pagoto et al., 2007; Wachtel, 2010; Westen, Novotny, & Thompson-Brenner, 2005). This narrative is furthered by EST proponents who postulate specific ingredient

therapies, for specific disorders (e.g Chambless & CritsChristoph, 2006; Baker et al. 2008; Barlow, 2004; Chambless & Hollon, 1998; Siev, Huppert, & Chambless, 2009). Provocative nomenclature is utilised to support the narrative; words such as efficacy, statistically significant, protocols and fidelity to manualised therapies are propagated as the gold standard. The implicit message is that if you are not using these therapies then you are not 'evidence based'. However, meta-analysis comparing manualised versus non-manualised therapies does not support this contention (Truijens et al, 2018; Vinnars et al, 2005; Navarro, & Phillips, 2000). Indeed with these therapeutic gold standards, one would expect the outcomes within the field to have progressed substantially over the decades, yet, research suggests that outcomes have not improved in 58 years (Weisz, et al, 2019).

Within the EST paradigm the person of the therapist is not considered important as an outcome variable, protocols and fidelity to theory and technique are said to mitigate for differences within and between therapist outcomes and effect sizes. This argument is counter to that of Baldwin and Imel (2013) who contend that the individual therapist accounts for approximately 5% - 8% of the variance in outcome; this is in contrast to Wampold (2001) assertion that a mere 1% of outcome variance is attributed to theory and technique . In addition to these concerns, other research suggests that studies from EST's don't always transition into naturalistic settings due to controls utilised to improve internal validity during randomised control trials; indeed, aggregated mean scores at the group level from studies are problematic in the transition to routine practice (Margison et al, 2000).

Common factor advocates contend that when the specific active ingredients are removed from empirically supported treatments in dismantling studies, the approaches still show outcomes equal to the full component therapy

Common Factors

Common factors refer to effective aspects of therapy that are shared by diverse schools of thought, they are non-specific. Those who purport a common factor approach point to a large body of evidence from randomised controlled trials and meta-analysis showing equivalents in outcomes between bona fide treatments when compared (e.g. Watts et al, 2013; Smith & Glass, 1977; Stiles, Barkham, Mellor-Clark, & Connell, 2008; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006; Wampold et al, 1997; Project Match 1998).

Moreover, common factor advocates contend that when the specific active ingredients are removed from empirically supported treatments in dismantling studies, the approaches still show outcomes equal to the full component therapy (e.g Cusack et al, 1999; Cahill et al, 1999; Bell, Marcus & Goodlad, 2013; Ahn and Wampold, 2001). Indeed, the latest fad of trauma informed treatments that include add on adjunctive therapies are not as clinically effective as proponents posit (Ulrich & Gergor, 2016).

In response to the proliferation of EST's, common factor proponents put forward an argument that therapeutic outcomes are the result of factors common to all bona fide psychotherapeutic approaches. Indeed, theoretical orientation/ techniques account for a minority percentage of variance in outcomes circa 1% (Laska, Gurman and Wampold, 2014; Wampold, 2001). As Lambert (2013 P.43) contends, "It will not generally matter which kind of psychotherapy is offered as long as it is a bona fide theory-driven intervention". The discourse within the common factor paradigm offers differentiated frameworks to conceptualise this phenomena (see Rosenzweig, 1936; Duncan, Hubble, Miller, 2010; Wampold & Imel, 2001; 2015; Duncan & Moynihan, 1999). Chambless & CritsChristoph, (2006 p.199) refute the common factor proposition on what would seem a rigid adherence to philosophical science based research; "Of all the aspects of psychotherapy that influence outcome, the treatment method is the only aspect in which psychotherapists can be trained, it is the only aspect that can be manipulated in a clinical experiment to test its worth, and, if proven valuable, it is the only aspect that can be disseminated to other psychotherapists". Nonetheless, the debate regarding if therapy works through the activation of specific factors, or through the interdependent variables of common factors remains, as we currently do not have the statistical power or methodologies in research needed to evidence causality (Cuijpers, et al, 2019). However, dismantling studies and equivalent outcomes within the literature provide strong

evidence against the specific ingredient propositions

Duncan (2014) puts forward the following conceptual framework (see figure 1) to understand the common factors and their interactions.

> The percentages are best viewed as a defensible way to understand outcome variance but not as representing any ultimate truths. They are meta-analytic estimates of what each of the factors contributes to change. Because of the overlap among the common factors, the percentages for the separate factors will not add to 100%." (p. 23).

Practice Based Evidence

Outcomes are an area to come under increasing scrutiny by academics, managed care providers and commissioning bodies in recent times. Swisher (2010) explains the concept of Practice-Based Evidence as, "the real, messy, complicated world is not controlled. Instead, real world practice is documented and measured, just as it occurs, "warts" and all. It is the process of measurement and tracking that matters, not controlling how practice is delivered". Psychosocial interventions delivered within therapeutic settings are well established within the extant literature as having strong evidence of efficacy and effectiveness (Lambert, 2013; Lambert & Ogles, 2004; Fonagy, Roth, & Higgitt, 2005). Meta-analytic studies conclude that recipients of such interventions greatly benefit when compared to non-treated individuals with aggregated effect sizes ranging from 0.75- 0.85 (Hansen, Lambert, & Forman, 2002; Wampold & Imel, 2015; Lambert, 2013).

Nevertheless, the overall effectiveness of counselling and psychotherapy has not progressed and developed in relation to client outcomes in over four decades, despite the emergence of hundreds of empirically supported treatments (Weisz et al, 2019; Wampold, Mondin, Moody, & Ahn, 1997). This data can be inferred to suggest that there is something other than specific therapy ingredients based on diagnosis-treatment paradigms at play. This is further reinforced with longitudinal research in naturalistic settings suggesting that on the whole, therapists became slightly less effective over time (Goldberg et al, 2016). Moreover, a body of research illustrates that approximately 5-10% of those engaged in counselling and psychotherapy actually deteriorate while in treatment (Hansen & Lambert, 2003; Hansen, Lambert & Foreman, 2002; Lambert & Ogles, 2004; Mohr, 1995). More worryingly, this statistic is higher for young people (Nelson et al, 2013). Lambert (2017) postulates that 30% of patients fail to respond during clinical trials, and as many as 65% of patients in routine care leave treatment without a measured benefit.

Randomised control trials and meta-analysis within the literature on routine outcome measurements suggests that intentionally eliciting live feedback from clients within sessions can improve therapy outcomes, reduce dropout rates, and identify those at risk for deterioration

Randomised control trials and meta-analysis within the literature on routine outcome measurements suggests that intentionally eliciting live feedback from clients within sessions can improve therapy outcomes, reduce dropout rates, and identify those at risk for deterioration (Berking, Orth, & Lutz 2006; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004). Moreover, research posits that practitioners do not adequately predict the deterioration of clients, those at risk of drop out and null outcomes when they assess clients informally (Ostergard, Randa & Hougaard, 2018). Thus, the utilisation of such processes and procedures will serve to improve

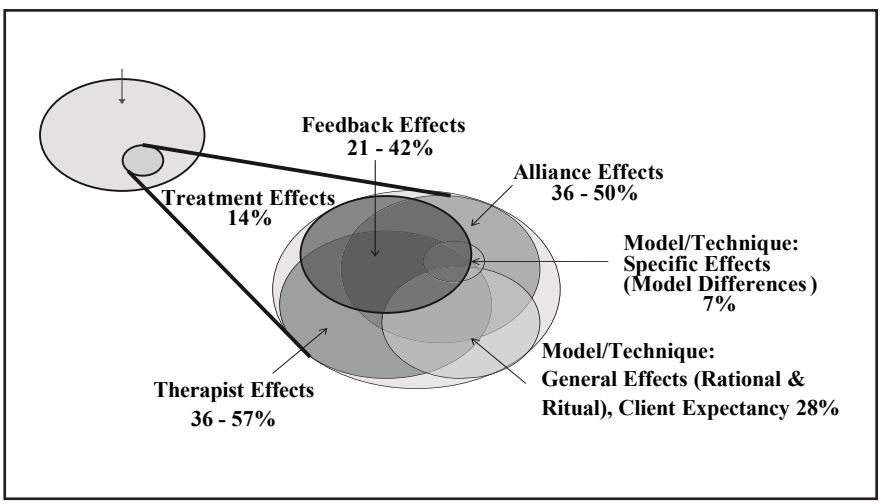

Figure 1 - Common Factors Conceptual Framework

outcomes for practitioners. This is further reinforced by several studies that contend that the use of such feedback systems produce outcomes that are 2.5 times better than treatment as usual (e.g Brattland, et al, 2018) and that its use can cut rates of those at risk of deterioration and drop out by 50% (Berking, Orth, amp, Lutz 2006; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, Tuttle, 2004).

According to Phelps, Eisman, & Kohout, (1998) despite the numerus measurement methodologies at the disposal of therapists few clinicians utilise them, and outcome data collection is rare. Hatfield and Ogles (2004) conducted a national survey of psychologists and found that uptake of such instruments was limited due to perceived barriers such as; time and money, and practicalities of their in session brevity. Interestingly, this links to wider issues of underutilisation of Routine Outcome Monitoring (ROM) data by therapists (Lambert, 2017; Simon et al, 2012; de Jong et al, 2012). Carlier and Van Eeden (2017) suggest that training should be provided to clinicians in administration, interpretation and using feedback to discuss treatment, stagnation, decline and goal setting with clients.

In response to some of these concerns, Miller and Ducan (2000) developed two short 4 question instruments to measure outcomes based on a shortened version of the Outcome Questionnaire 45. The first, the *Outcome Rating Scale* (ORS) captures data on client progress that can be aggregated in order to determine therapists overall effectiveness. *The Session Rating Scale* (SRS) assess the quality of the therapeutic alliance which is a key indicator of the effectiveness of therapy (Wampold, 2014), it is based on a shorter version of the *Working Alliance Inventory.* Both instruments can be administered in different modes (individual, couple and group therapy; with adults, children and adolescents; and across differential clinical presentations. Moreover, each scale has clinical cut off rates depending on the clients' age linked to normative data. Taken together, both these reliable and validated (Duncan et al, 2004; Miller et al, 2004) psychometrically sound outcome measures make up the main components of a pan-theoretical approach, Feedback Informed Treatment (FIT) which has Evidence Based Practice status in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry.

Interventions must be acceptable to clients' cultural values, and preferences, and make sense to their idea of the presenting issues, onset and possible treatment options.

Evidence Based Practice Operationalised

Thus far, we have examined one of the main discourse debates within psychotherapy. Common factors and empirically supported treatments pitted against one and other, fighting for position as the most prominent method. However, this paper contends that such rivalry is based on a false dichotomy as both aspects are interdependent and necessary for therapeutic change to occur. Therefore, this paper puts forward a framework for practitioner integration based on the full utilisation of the evidence based practitioner framework including practice based evidence and empirically supported treatments.

In order to achieve a fully integrative approach we must turn back to the evidence based practice framework and the common factor model. Evidence-based practice as the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (APA, 2005).

So, to operationalise this framework what must our practitioners do? Integrate the best available evidence? The literature provides us with rigours evidence of several factors that work in therapy. However, when it comes to the theoretical orientation aspect of what works the current debate splits opinion. What we can say is the following; the average treated client is better off than approximately 80% of untreated people; research provides strong evidence for bona fide therapies and there utilisation, however, the role of specific ingredients versus common factors as change agents may not be as important as the integration of both into a uniformed model. To this end, practitioners are best placed to choose therapies that best fit their worldview (allegiance effect); that they can explain the rationale for the use with clients; and that offer up a theoretical explanation to the clients presenting issue with a set of corresponding techniques/ rituals. However, interventions must be acceptable to clients' cultural values, and preferences, and make sense to their idea of the presenting issues, onset and possible treatment options. Evidence supports these factors as producing favourable outcomes mediated through the therapeutic alliance, client expectancy, instillation of hope, placebo effect

and practitioner allegiance to the therapy. Providing this within the confines of the clinicians' expertise means that the practitioner uses all their experience and knowledge garnered through education, clinical experience and ongoing research in conjunction with the person they are working with and their worldview.

Finally, practitioners will be best placed by utilising a Routine Outcome Monitoring system to track client progress, identify those at risk of deteriation, and drop out and those responding to interventions. In addition, data from ROM can be utilised for therapists to actively and intentionally improve upon areas needing further development by providing baseline outcome stats. Chow et al. (2015, p. 337) refer to this method of therapist development as Deliberate Practice. "Consistent with the literature on expertise and expert performance, the amount of time spent targeted at improving therapeutic skills was a significant predictor of client outcomes". Moreover, eliciting feedback in this manner not only invites clients to be full participants in the therapy endeavour, it also offers a common ground between the internal validity of research trails of EST's and the evidence based practice of integrating EST's into real world practice to fit individual characteristics, preferences, values and the multitude of complexities humans bring to the therapy endeavour.

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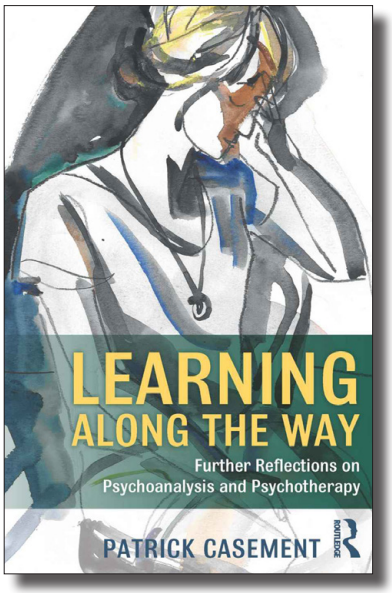
Book Review

Title:	*Learning Along the Way: Further Reflections In Psychoanalysis and Psychotherapy.*
Author:	*Patrick Casement*
Published:	*2019*
ISBN:	*ISBN: 978-1-138-34354.*
Reviewed by:	*Anca Filip*

Learning along the way, a compilation of earlier published papers, makes a natural pairing for Patrick Casement's first book, *On Learning from the Patient*. In it, he reflects upon his life's work over the past fifty years, following an autobiographical journey from a suicide attempt, to careers as a social worker, psychotherapist, and psychoanalyst. The book concludes with an account of Casement's near-fatal encounter in later life with an unexpected illness.



Throughout the book Casement explores different ways of working and listening, helping us to consider ways of thinking that might help us to better understand what we are hearing from our patients. He is acutely aware of how difficult the analytical process is for both analyst and patient, and alerts us to some of the factors that can threaten the analytical space. He is particularly sensitive to the danger of training institutes asking trainees to give up their minds to the theoretical orientation of their training organizations.

In fact, he demonstrates a fierce opposition to any dogmatic use of theory which imposes itself upon the patient and which could influence their experience to fit the analyst's own theory. "So we can engage with the otherness encountered in each of our patients," he insists, "we need to maintain an open mind" (p. 59). This is nearly impossible to achieve, however, "when our minds tend to be filled with what we are expecting to find" (p. 59). Casement's suggested solution is to "try to re-establish non-certainty" (p. 59). This, he insists, is the way "to recover an open mind and the freedom to continue exploring" (p. 59).

He emphasizes the importance of monitoring how the analytic space is possibly preserved or perhaps spoiled by the analyst's contribution. In so doing, he necessarily highlights the idea of mutual change and reciprocity in the therapeutic relationship which encourages an openness in the analyst to what he calls the "otherness of the other".

Casement returns throughout the book to several innovations in the psychoanalytic process and technique which he has developed to keep the analytic space open. These include trial identification, the process of internal supervision, and – from my point of view, the most important – learning from the patient. As professionals, following Casement's example, we have to recognize our mistakes and implicitly, to become vulnerable in the therapeutic space. Casement emphasizes the importance of a mutual recognition of failure as being very helpful for the patient. The effects of power in the relationship, and its influence on the possibility of mutual learning between analyst and patient, are well exemplified through the clinical vignettes.

A particular concern for Casement is that what is needed in the analytic relationship may have been overshadowed by a continuing influence of the medical model. He critiques the emphasis on the provision of short term cognitive behavioural therapies within the healthcare system, arguing that they do not provide enough time for patients to find their own path. They rely too heavily, he suggests, upon techniques provided by the therapist.

While exploring those cases where cognitive therapies might be of benefit, he is also mindful of how they can be appealing, simply because they are brief and financially affordable.

The last few chapters of this book are a collection of interviews; discussions with Kate Schechter and Thérèse Gaynor, along with Casement's 'Response to Stuart Pizer's review' of *Learning from our mistakes*. This piece echoes the famous Mrs M case from the earlier book and concludes the collection.

Throughout, Casement's clear, accessible writing creates a space where the reader can learn. I would have loved to have seen cultural factors taken more into consideration. Even so, I am grateful for this book, which shares a lifetime's experience of being a psychoanalyst, supervisor, and – most importantly – a human being. Casement's openness to sharing his mistakes, illness and wonderful vulnerability will influence generations of professionals.

Anca Filip is a pre-accreditied psychotherapist working in the Meath Primary Care Centre, Dublin 8. She can be contacted at ancafilip@counsellingservices.com.

Poetry

BULLYING

By Michelle Coyne

I want to be loved,

I don't deserve it

But I do deserve to be loved, I think

So why can't I be loved

Does anyone love me

Why can I not see it

What makes me blind to it

The Hurt, the Rejection, the Bullying, been Ignored

How did I come to this place

By train, by car, ferry or plane

Ah, now I remember

IT WAS YOU

YOU CARRIED ME WITH THE BULLYING, TELLING ME I AM NOT GOOD ENOUGH,

LAUGING AT ME, MAKING FUN OF ME IN FRONT OF MY FRIENDS

SNAPCHAT, FACEBOOK, INSTAGRAM AND MORE

IT NEVER ENDS

THEY TURN AWAY

NOW I AM REJECTED .... AGAIN AND AGAIN

Does anyone notice me

Have I become invisible

Someone sees me,

I have to look up,

Who sees me

My parents or

My teacher or

An aunt, an uncle

Maybe a cousin

Maybe it's the shop keeper who calls me by my name but I have never noticed before

Hello, my name is .....

What is yours

You who hide behind your masks of cyber bullying

I asked; What is Your NAME.....

Stop hiding

Stop being afraid

STOP STop Stop stop, shhhh!

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