(Body) Psychotherapy is a Craft Not a Science![35]

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Abstract

This article argues that the whole direction of assessing psychotherapy by scientific criteria is a fundamentally mistaken one, and that, like many other professions, the actual practice of psychotherapy is much more of a skill-based craft. This practice can inform science and can certainly be informed by science, but it is definitely not a science in itself. As the profession emerges, the attempt to try to establish a credibility for itself as a 'scientific' discipline – an '…ology' – a study of material facts – is a mistaken one, and is detrimental to the actual art and practice of the profession. This argument applies even more pertinently to Body Psychotherapy.

Introduction

It is our contention that psychotherapy, the one-on-one practice of (usually) verbal therapy and psychological counselling is really not a science: it is much more of a 'craft', a set of specialized skills. A 'science' is something completely different.

The reason for promoting this point of view about psychotherapy (here in this article) is that there is, in the UK and in Europe, the beginnings of an increasing 'requirement' to 'scientifically validate' psychotherapy, and

[35] This article was originally written *with* Michael Heller and was published in the *International Journal of Psychotherapy, Vol. 5, No. 2, pp. 113-132.* Michael Heller has since distanced himself from this article, and his written his own book on Body Psychotherapy, soon to be published by W.W. Norton & Co. Ltd. This article has been substantively re-written since then.

now any (or and every) particular branch or modality of psychotherapy. However, not much has been written publicly about the actual need for the scientific-validation of psychotherapy, though much has been written about 'evidence-based' psychotherapies (mainly in relation to CBT): this is actually not the same thing. So the (original) title of the article[36] was phrased slightly contentiously, with no particular agenda other than a strongly felt desire to get this subject considered as widely as possible before we, as a profession, irrevocably hamper ourselves with the heavy weight of an unnecessary millstone that we have tied around our necks or our ankles before we launched ourselves into this particular millpond or swimming pool.

Unfortunately, there seems to be a commonly-held assumption within the profession that we need this millstone; we need to be 'scientific' or, perhaps more correctly, we need to be *seen* as 'scientific'. If this really is the case, then we are therefore going to sound a little like 'devil's advocates', trying to stop the river or arguing against the mainstream direction. But there is a place for this argument, as well. It is not an 'either … or' situation; psychotherapy (and Body Psychotherapy) is a craft! It also nowadays needs to be 'scientific' as well.

In previous articles in this series, and in the submission for the 'scientific validity' for Body Psychotherapy for the European Association of Psychotherapy (EAP) that we helped write in 1999, we wrote about the (currently rather poor) evidence-base for Body Psychotherapy: our own particular mainstream or modality of psychotherapy. This, as in other modalities, is expanding gradually every year. One indicator: the EABP Bibliography of Body Psychotherapy now has well over 4,500 entries and is available on-line. Another indicator: the number of professional journals and conferences in Body Psychotherapy is steadily increasing. Another indicator: close links are being formed with neuroscientists and researchers, as described earlier (Young, 2011).

All this forms a small part of *an* evidence-base for this particular Body Psychotherapy modality or mainstream, though usually "evidence-based psychotherapy" refers to a psychotherapy with sufficient 'scientific evidence' (usually meaning Randomised Controlled Trials) that supposedly

[36] "The Scientific 'What' of Psychotherapy: Psychotherapy is a craft, not a science!"

demonstrate the efficacy of the method. Furthermore, what is 'sufficient' and what the conclusions are that one can draw from the available evidence, are two totally different things.

It is perhaps unfortunate that we live in a 'scientific' age. Many different perspectives abound about what science is, and what is not a science, and how this might apply to psychotherapy, and thus there is a great deal of confusion. There is a collective myth of science being the ultimate arbitrator, *Deus ex Machina* and, as a contrast, there are also very many examples of 'bad science' (Goldacre, 2008) and ways in which 'scientists' have been condemned by the status quo, which did not 'like' the evidence.

In another age, psychotherapy might have been a mystic art (similar to Druidic magic), a religion, a craft skill, a philosophy, a healing technique, or a social phenomenon, and just maybe it is all of these today as well. We shall briefly look at some of these views later. But when we consider the scientific validation, or the evidence-base, or the efficacy, of psychotherapy, we have to be extremely clear whether we are referring to something that is absolutely necessary to the establishment of a new profession; or – and this is crucial – whether this is going to be 'required' as a method of political determination and part of the process of establishment acceptance by with 'the Establishment'; or is it just an academic exercise, a form of vocational assessment; or a method of self- or external scrutiny and self-validation. Why are we actually going down this route? Was it because of some decision made in an Austrian ministry; or a governmental Department of Health; or did a professional association (like the EAP, APA or EABP) 'conform' to this requirement in order to get more widespread recognition – and health payments? And, if so, why are we still running along in this same direction? Does it really serve us? These sorts of questions start to bubble up as soon as the lid on this particular 'political' pot is lifted.

If psychotherapy is truly a science, or if it is truly scientific, then we have no objection to this. We are not romantics, or Luddites, dreaming of an earlier age. Indeed, both of us were heavily involved in the major submission in about the scientific-validity of Body Psychotherapy that was accepted by the EAP in 1999. So we have been there, done that, and got the T-shirt. Now we are also asking whether (a collective) we – as a mainstream branch of psychotherapy – really need to wear the T-shirt, in order to 'establish' our credentials.

The argument of entrenched psychologists and psychiatrists (in some

European countries) that psychotherapy is much more of an activity … 'only to be done by qualified psychologists and psychiatrists' and that this perspective, which needs to be seen as parallel to an academically and scientifically-based psychology, is being steadily eroded by the EAP's training standards for the European Certificate of Psychotherapy (ECP), by the establishment of the Professional Competencies of a European Psychotherapist, and also by several court cases that demonstrate that this perspective is essentially a ;'restrictive practice' and not condoned by the European free-labour market. Essentially, all the work in the EAP establishes a basic model for a specialist professional training in psychotherapy of at least four years, with a post-graduate level of entry, (i.e. similar to at least three years of previous relevant academic qualifications at university level, or the equivalence in work study and experience). This makes a minimum total of at least 7 years of relevant study and professional training after leaving school at 17-18, and a minimum total of about 3,200 hours of training. Assuming that the average three-year university course (or the equivalent) takes about 500 hours p.a. of tutor time, that still leaves about 425 hours per annum for the 4 years of post-graduate training (1300 hours total). This is a powerful amount of time spent on 'learning' the professional activity, or craft. There is little requirement (perhaps unfortunately) for a 'scientific' module.

This equates psychotherapy with most other professional trainings across Europe. So, these professional training standards have now been established and about 6,000 psychotherapists have shown that they (approximately) meet these standards by being 'grandfathered' onto the EAP's Register. About 50 training schools have also been accepted as training according to these standards and thus their graduates can get the European Certificate of Psychotherapy (ECP) on completion of their training. Conservatively, there are about 120,000 psychotherapists in Europe that have been trained approximately to these standards and within these criteria. This establishes a rather significant evidence-base against the argument that psychotherapy training should be just an additional module for psychologist and psychiatrists. There is therefore a substantial basis for arguing that, since this profession exists, it should be allowed to exist, rather than new laws coming in which raise goalposts and disenfranchise people who have been working for many years.

The existence of such a large body of professional psychotherapists should not be threatened by the protectionist views of an already established

profession, with many branches and other activities. The existence of the EAP does not directly threaten the European psychologists or psychiatrists, However, their position, mentioned above, directly threatens the continuance of the EAP. They are saying somehow, somewhere, that we shouldn't really exist, because we are trying to do professionally what they think that they do, or that they think they should be the only ones to do: this is pure protectionism.

Luckily, whilst there are laws in several European countries, these are gradually being tested out in the courts against the over-riding European legistlation, and we are seeing that this 'protectionist' position is clearly being judged as being against the basic ethos of the European Union, which is to create a free labour market. One or two significant cases have already been won: several more will follow inevitably. So, if a state-registered psychotherapist from country which accepts a pluralistic perspective moves to a country which is protectionistic, they win in the courts because of the superior European principle, and this blows a hole in the national (state) law. I have gone into this in some depth, so as to emphasise that the legal position of psychotherapy is very different from the scientific position. Yet the stated rationale of the legal position is often on a spurious scientific basis.

Reasons for validation

There are several political and social reasons for wanting to 'validate' psychotherapy 'scientifically', but mostly they come either from within, or from other competing professions. One of these is the profession of psychology. There is a very strong political, and almost certainly financially motivated, argument within that profession that 'psychotherapy' is not, and should not be, the independent profession that it clams to be – as for example in the 1990 Strasbourg Declaration on Psychotherapy, but instead that it 'psychotherapy' is merely a therapeutic activity that is the legitimate practice of, and should only be done by, qualified psychologists and/or psychiatrists. This is largely the position held by the psychological/political establishment in Germany, Holland, and Italy. It is also the view held by the European Federation of Psychologist Associations (EFPA: www.efpa.eu) who passed a motion to this effect some years ago. It has some relevance in America as well, dominated by the academic teaching of psychology and psychotherapy, though, in most USA states, licensed social workers and some other professionals can practice psychotherapy as well.

Often the reasons quoted for this perception are that psychologists are properly qualified because they have studied the subject properly; i.e. there is an established academic discipline, at a university, or that, as their training has academic and scientific components, they are properly 'scientific'. Psychotherapists, who (in Europe) are much more experientially trained, often not at a university, are therefore *de facto* not properly 'scientific', and thus they are a danger to the public – or so it is argued. Whilst the first part may have a little truth in it (many European psychotherapists are not trained in psychotherapy at a university and are not very scientific), the last conclusion forms a totally spurious argument.

First, as a newly emerging profession, we can easily ensure that sufficient, and sufficiently rigorous, training modules are inserted to ensure that the training meets any acceptable level of professional standards, and this is slowly being done. There is a very strong argument for ensuring that all psychotherapists should have a sufficient understanding of scientific research to be able to comprehend research papers, and to be able to discriminate between good research and bad research. So far, this has not resulted in any such requirements being inserted into the EAP training standards. So, interestingly, whilst we may struggle for scientific acceptability, we ensure (by omission) that the members of our profession have no real understanding of science; we therefore internally demonise 'science' and mystify our 'craft'.

Secondly, during an exercise in the 1990s in the UK, there was an attempt to establish National Vocational Qualifications (NVQ) for psychotherapy. These were to be the appropriate functional competencies to be applied to psychotherapy trainings: the actual practical skills that would need to be demonstrated by a person completing a training course in psychotherapy. The main focus was – as it should be – on all aspects of the client-therapist relationship: starting a session; making a diagnosis; fixing a contract; etc. Academic psychology played very little part in these functional competencies. Scientific analysis of research was also not mentioned (that we remember) but it could have been: nor was the ability to discriminating out between spurious lines types of argument, though it certainly should be, –as it this is certainly a useful scientific tool (see Goldacre, 2008). However the attempt failed then – mainly for political reasons, but also because these skills cannot easily be accurately determined accurately.

A new attempt is being conducted with the European Association of

Psychotherapy in 2010 (see www.psychotherapy-competency.eu). These skills (functional or professional competencies) will eventually inform or determine the training in psychotherapy, as Europe moves us more and more towards this universal method of assessment of what is or is not within a profession. Body Psychotherapy will be taking part in this process and so we should, at some point soon, be able to see what the skill-base (craft) of Body Psychotherapy entails.[37]

These two examples maybe give an indication that the majority of the psychotherapeutic profession in Europe actually believes in the subtitle of this article, or practices as if it were true: psychotherapy is really a craft, not a science. If it were a science, then such components would have been / should be inserted into the training, as a matter of course, or necessity. Their omission is therefore tellingly significant. Psychotherapy needs to get very clear what the arguments are, and what the arena for this context really is. And we, the authors, maintain that the scientific arena is probably / possibly the wrong one, for the present situation: we make no comment (yet) on how it should be.

Another argument, this time from the psychiatric profession, is that largely 'unqualified' psychotherapists are incapable of recognizing, let alone working with, psychotic patients – i.e. there are sufficiently high medical diagnostic parameters involved that exclude necessitate the 'medical' practice of psychotherapy. Again this argument is more than spurious, it is also somewhat insulting. It is also logically and practically demolished by the inclusion of the EAP's Training Standards of a compulsory training module on psychopathology and a definite specification of experience in a 'mental health' setting (i.e. some supervised medical or clinical work experience or secondment).

This means that, in order for anyone to obtain the European Certificate of Psychotherapy (ECP) in the future, they will have to have done that placement – but they still will not have to had to have done a 'scientific' module. A similar 'clinical' component in the UKCP Training Standards was considered sufficient by the UK's Royal College of Psychiatry. The training of clinical psychologists in the UK has similar components, and of not much

[37] The Chiron Association of Body Psychotherapy (CABP) in conjunction with the London School of Biodynamic Psychology (LSBP) and the Cambridge School of Body Psychotherapy (CSBP) have recently (June, 2012) produced a draft of these professional competencies for Body Psychotherapy.

greater length, and this has found to be largely satisfactory. The European Federation of Psychologists' Associations (EFPA) has a similar set of training standards for those psychologists practicing psychotherapy.

In fact, the clinical training of clinical psychologists is often a lot less experientially-based than that is proposed for psychotherapists, which might suggest that their experience of actually working in such psychotherapeutic situations (and with psychiatric clients) during training is relatively limited: they could thus be considered as being somewhat 'skill-challenged' when they come to do the 'craft' work of actual psychotherapy.

There is a further argument, usually pulled out as a killer-clincher argument to undermine the psychotherapist's position. This is a view held mainly in the medical profession (psychiatrists), and it is that psychotherapy is largely ineffective and highly uneconomical; i.e. medication is much more cost-effective. This argument brings in economics (and politics) and the increasing influence of health insurance schemes, either state or private, similar to the situation that exists in the USA. These are not scientific arguments.

Let it be clearly stated that there is a considerable body of scientific research (done mostly in America) which demonstrates very clearly that psychotherapy is (**1**) sufficiently effective by itself; (**2**) especially effective in conjunction with medication; and (**3**) that all the main types of psychotherapy are reasonably effective, though some types are slightly more effective for certain symptoms. Overall, there is very little discernable difference between the different modalities.

Finally, (**4**) there is a clear indication that the most effective factors in psychotherapy are (**a**) the relationship between the therapist and client, and (**b**) the motivation of the client. These are two very 'non-scientific' measures and again lend weight to the 'craft' argument. So, we may have here another repetition of the phenomenon that a widely-held belief outweighs any scientific evidence to the contrary. We also have a clear indication – from the research – that the skill (craft) – and personality – of the psychotherapist is a significant factor.

Given all these arguments ranged against psychotherapy, it is understandable (if inexcusable) that it was thought necessary to establish the scientific basis for psychotherapy. However, one doesn't necessarily fight fire with fire. Water is sometimes more effective.

There is another, very different argument that exists around the science

or 'scientificism' of psychotherapy: this was mentioned in an earlier article (Young, 2010). This is based on the basic difference between two types of 'science': 'natural science', that study the rules and laws of nature, objects, with randomised controlled studies, re-testable hypotheses, theories being developed into facts, and the like; and the 'social sciences' that study human beings, animals, trends, dynamics, and processes, using a different *a priori* methodology. Unfortunately, many people seem to elevate the former and somewhat denigrate the latter. This then leads to psychotherapy being squeezed to conform with the 'natural' science model, especially with the close associations to the medical & psychiatric profession, and this 'medicalises' the psychotherapy, turning the client (who is the one supposed to benefit and transform themselves) into a patient with a diagnostically treatable illness who needs to be 'cured' by the therapist. This process has many ramifications.

Attempts at validation

In order to try to avoid many of these arguments, when the Scientific Validation Sub-committee of the EAP Training Standards Committee was established to look at this area, a set of criteria was initially suggested which might have avoided the ensuing debate. It was a form of pragmatic assessment about who amongst the various types of psychotherapies might be considered 'in', and who might need to do a bit more work before they joined the club of mutually accepted types of psychotherapy. These criteria were not scientific and were deliberately not meant to be so; they were very simply pragmatic and political: and yet they were rejected. It seems that, as an emerging profession, we wanted (desperately) to be regarded as really 'scientific'. And this phenomenon is something not confined to Europe. Incidentally, the criteria chosen (the EAP's 15 Questions) were reasonably 'scientific' and were also chosen by an eminent Body Psychotherapist. This is explained in more detail in an earlier article in this volume.

A definition of science

Science is a series of procedures: methodological and often institutional, a logical way of thinking and of gaining further information, thus increasing one's knowledge about a certain topic. There are experimental sciences (e.g. chemistry and biology) and theoretical sciences (e.g. cosmology); and there are also clinical sciences (e.g. medicine and psychology dentistry) and, as

mentioned, social sciences (psychology and sociology). Each of these sciences interestingly enough have totally different procedures what are particularly adapted and suitable to that form of study – the 'logos' – of that particular branch of knowledge. Science, in the wider view, is a complex institutionalised set of strategies with ideological and economical intentions and methods of approaching knowledge.

Relying on just proofs and validations, which are often quoted as crucial issues in the determination of ideas and the expansion of knowledge, is a non-scientific view of science. These may form part of some sciences, but usually more of the experimental branches. There can be little 'proof' (and very few double-blind tests) about what happened in the first few seconds immediately after the 'Big Bang' in the formation of the universe, but much of the *science* of cosmology and particle physics centres around this precise issue. And here we also find a totally different form of science emerging.

Holistic Science explores new trans-disciplinary methodologies that are gaining success in explaining natural systems. These recognize that complex systems have "emergent properties" that describe their characteristics as wholes and that these properties are conditioned, but not determined, by the system's constituent parts. A reductionist explanation of nature is not only incomplete; it can also be dangerous. It leads us to assume that by analyzing the "mechanical" workings of nature we can predict and hence manipulate it. In genetic engineering, for example, conventional scientists believe that genes are of primary importance in determining all the characteristics and behaviour of organisms. Holistic science recognises that a methodology that ignores the ecological context, complexity, emergent properties and intrinsic value of life, cannot capture the whole story. This sort of science might seem more appropriate to psychotherapy and Body Psychotherapy.

Further aspects of scientific development in Quantum Theory and the more obscure aspects of theoretical physics and cosmology are discovering intriguing aspects of what we might call 'Holographic Science' (Talbot, 1996). This is a totally different perspective on science and this perspective may be much more relevant for Body Psychotherapy in terms of 'energy fields', somatic resonance, etc. But we, in Body Psychotherapy, will have to demonstrate that this science is more relevant to our work.

Furthermore, science has created an orthodoxy, which, like many others, claims a monopoly on truth. Gill Edwards (1992) argues that science sees the

natural science form, the 'scientific method', as the only valid path towards knowledge, and since it tends to ignore s whatever does not fit this paradigm, it is satisfyingly self-fulfilling. However, this debases and debunks alternative versions of reality, which may be based more on intuitive knowledge or subjective experience. It is precisely these areas that are often paramount in psychotherapy, and especially in Body Psychotherapy. Science excludes them; erroneously we claim. Psychotherapy, and Body Psychotherapy, it can thus be argued, fall more perhaps into the field of metaphysics, which is where it has can maintain its richness, its soul. But, if that is the case, then we need to prove it.

Science is also inherently self-limiting. There are pockets or parameters where it is (reluctantly) admitted that more work needs to be done. The 'authority' of science is such that its adherents have problems (sometimes) in acknowledging the limitations of their knowledge. In all fairness to many scientists, this is not true on an individual basis, but collectively the public and the media love to find the chinks in their armour. To acknowledge that there may be whole vistas that are relatively unexplored becomes quite threatening and undermining to what has been discovered.

In the recent research about 'subtle energies', especially in the field of complementary medicine, whilst scientific methods have been rigorously used, science cannot (or is very reluctant to) accept the findings. Cleve Backster's (1968) work in the late 1960s and early 1970s on communication with plants and inter-cell responses over distances was using new forms of 'science', and, whilst this work was 'refuted' (Horowitz, Lewis & Gasteiger, 1975); Kmetz, 1977), it may be – as is often the case – easier to find flaws than accept new paradigms. The same applies to the work of the Institute of Resonance Therapy in Cappenberg, Germany on restoring ecosystems. This work is highly scientific, and yet it is totally unacceptable to mainstream science because work in this area postulates either energies existent in the 'fuzzy' end of the electromagnetic spectrum, which are (currently) too subtle to measure; or, alarmingly, that subtle energies exist in correspondence with, but parallel to, the electromagnetic spectrum, and may not have exactly the same constraints of that spectrum, such as the speed of light (von Ward, 2000). This is too radical (unnatural?) for most natural scientists: so again it is easier to dismiss this type of science.

Many of the phenomena of these subtle energies are what we, as

psychotherapists and especially as Body Psychotherapists, work with – consciously or otherwise (Davidson, 1987; Collinge, 1998; Gerber, 2001; Oschman, 2000; Kepner, 2003). And – what we are not doing – is claiming this ground, on the basis that it may be seen as 'unscientific'. That gives us a problem: we may need to contribute to the science of these areas, so as to establish a solid ground on which to stand.

There are also recent theories, developed mainly by Stanford neurophysiologist Karl Pribham, that strongly suggest our brains function holographically. Despite being supported by a lot of other evidence, little psychological research seems to have been done with this and it has been largely ignored (Talbot, 1996). However, it is being increasingly quoted and this aspect of science may well come into its own sometime soon.

The role of psychology

Psychology is, for the most part, a 'science'; but it is definitely not completely a science. It is a body of knowledge – a 'logos', and much of modern psychology is based on experimentation – often with rats, cats, and other mammals. It is also informed by other sciences; anthropology, sociology, human biology, physiology, etc. It is also assisted by the practice of clinical psychology – and this is where things get linguistically confused, as most clinical psychologiests practice a type of psychotherapy.

The "psych" realm of studies (psychology, psychiatry and psychotherapy) is generally recognised as scientific, mainly because it wants to become scientific. Scientific formulations are thus an aim towards which every branch of this field is trying to achieve: through scientific exploration of data, scientific data management, and scientific theorizing (e.g. based on data and on the literature). Experimental psychology is recognized perhaps as the most scientific branch of these disciplines. This recognition comes from the capacity experimental psychologists have of presenting decent psychological data (e.g. findings that can be replicated), and data management (e.g. the data can be analysed statistically). Nevertheless, even for the American Psychology Association, experimental psychology has not yet managed to become a truly scientific discipline (Koch & Leary, 1985/1998). Their arguments are basically the following:

1 Psychology's object has not yet been defined. *"In short I discovered that psychology is an intellectual zoo – a situation that has long prevailed, but*

from which I was carefully shielded in my youth."(Miller, 1985/1998)
This echoes other criticisms:

> Parts of psychology either is, or could be, or never will be a science. Parts of psychology are clearly scientific, in the best sense of the term, and other parts are pure moonshine. By picking your examples carefully you can make psychology and psychologists out to be almost anything that pleases your fancy at the moment. (von Ward, 2000)

2 Psychologists have avoided the study of psychological phenomena *per se*. They focus for the moment on phenomena that are influenced by the psyche (e.g. physiology and social norms), or phenomena that are influenced by the psyche (e.g. behaviour):

> Immediate experience took a back seat to other concerns – to behaviour, conditioning, the unconscious, mental testing, and a broad range of professional applications in education, industry and medicine – leading to the intellectual zoo that we inhibit today. Every large psychology department is today a small college unto itself, with a faculty able to teach a little bit of everything: optics, acoustics, physiology, pharmacology, histology, neuroanatomy, psychiatry, pediatrics, education, statistics, probability theory, computer science, communication theory, linguistics, anthropology, sociology, history, philosophy, logic, and, when time permits, psychology. (von Ward, 2000)

Daniel Robinson (1977) also gives us an example on how American psychologists have attempted to avoid facing the crucial problems of psychology:

> Psychologists have jettisoned the very problems and issues that had traditionally excluded psychology from the pantheon of sciences, while at the same time embracing a different class of problems suited to the methods of the developed sciences. The strategy – some might call it a ploy – takes this form. One discovers that the issues bequeathed by history are simply intractable when approached with the tools of experimental science. But, having adopted just those

> tools, one then proceeds to locate a number of subsidiary problems (or non-problems) tailored to the now official methods. Then, after years of success solving these, one declares that the original problems were not problems at all, for if they were the official methods would have solved them too!

3 Personally, we see a third major defect: there is no procedure for theorization. Since Helmholtz (1995), in the 1860s, psychology could produce interesting data, managed adequately from a scientific point of view. But even today's theorization is made of odd strings scientists find in their imagination. There is no proper methodology for theorization. Ideology and philosophy always had a predominant role (e.g. Vygotsky); current fads also include some and exclude others (e.g. Paiget). Thus, at the end of his career, in 1986, James J. Gibson, the world famous expert on perception, is still looking for a new Galileo, as he makes these depressing evaluations of psychology's achievements in his field:

> The conclusions that can be reached from a century of research on perception are insignificant. The knowledge gained from a century of research on sensation is incoherent.

A fresh start has to be made on this problem of perception:

> Our experiments have been misconceived. Has anything been accomplished? In a hundred years psychologists have found out a great deal about input thresholds, about the impressions that correlate with intensity of stimulation, about methods for applying stimuli to an observer so as to elicit judgements; and physiologists have found out how to do microelectrode recording. But these curiosities seem to be irrelevant or incidental to the practical business of perception.

Psychologists are amongst the first to see that, as a science, their approach is a new enterprise that is still attempting to define its object. Amadeo Giorgi (1970), for example also notes that between 1879 (e.g. G.H. Lewes) and 1979 (e.g. J.R. Krantor) no real accumulation of knowledge has occurred. He argues that a phenomenologically oriented 'human' science is an alternative paradigm to the current tradition of 'natural' science psychology. Some

questions are now raised without quoting previous attempts to answer this question. What can be noticed is that *"the phenomena of behaviour and experience have resisted scientific analysis because they have not been conceptualised correctly and therefore we have had difficulty in knowing how to study them"*. The difficulty is an obvious one: how can humans conceptualize how they conceptualize, understand how they understand, or explain how they explain? No amount of data can replace good thinking, and psychologists often seen to prefer the more mechanical activity of data gathering and counselling than in-depth thinking.

People who clearly seem to know what science is about largely form the membership of the APA, and they know what type of knowledge they are aiming at. They may or may not be right; but they do know what they want. If psychotherapists pretend that psychotherapy is already a complete science, they clearly know nothing of science. If Body Psychotherapists want to ground themselves in appropriate psychological science, then maybe they also need to join the APA and form a new division of 'Somatic Psychology' and be accepted as having a valuable contribution to make.

Non-conscious knowledge

The knowledge of the psychotherapist is often not even unconscious: it is non-conscious. It is described in the realm of knack and dexterities that neurosciences and studies on non-verbal communication are only just beginning to describe. Non-conscious knowledge is incredibly rich, subtle, complex and efficient, *"but by definition it cannot be reached directly through conscious introspection. To learn to become a racing champion you a) need to be gifted, and b) to run and run and run"*(Lemaine & Matalon, 1985) and see what sort of models and theories and stimulations help you to improve. The same can be said for piano, composition, singing, dancing, writing, and – *"psychotherapy. What is really involved in these incredible capacities developed by humans is not yet known, how we acquire this type of knowledge is unknown."*

But we **are** beginning to establish that it is non-conscious. We, the authors, also contend that 'how' the data of becoming a psychotherapist is defined and managed is also non-conscious. Our organism acquires these capacities by exposure to various psychotherapies and psychotherapists; by receiving extensive experiential training; by practicing under supervision; by making

mistakes, identifying and correcting them, and learning from them; by developing a sense of what is right or wrong for any particular situation; by an empathic dance between various clients; and by pouring as much relevant knowledge into our brains as we can. This acquisition of skills is much more like the long experiential training of an apprentice to a medieval craft or guild, than learning a 'science' (which should be able to be written down and understood intellectually from textbooks).

Thus theories in psychotherapy are constructed a bit like theories in experimental psychology, but their main aim is mostly that of a motivator. They motivate the psychotherapist to keep on trying to evolve in an often difficult, ungrateful and painful job. They make him or her believe that s/he somehow knows something: that keeps them going. The only problem with these theories is that they seldom describe the non-conscious knowledge that helps the psychotherapist to become efficient, or even elegant in their work. The theories do not even mention a notion similar to the non-conscious, which was nevertheless described by Helmholtz & Wundt in the 1850s (Richards, 1980).

In other words, the educated amongst us tend to manipulate theories that take into account the literature at their disposal, (and I am equally guilty of that), but very few people see are able to theorize on the data that really helps them work effectively. Which is to say that, in effect, although psychotherapists have a scientific aim or ethic, their theories are mostly motivational for their own purposes and ends. This, sadly, is not science.

Psychotherapy is also pretty soul-less. *"(It) strived to emulate the materialist sciences, and lamentably rejected the more ephemeral, more subjective, more enthralling aspects of human experience in favour of the rational, tangible, measurable, and quantifiable."* (van Deurzen, 1996)

Additionally there is the severe problem of dualistic thinking. Many people still think of 'mind' and 'body' still as separate entities. A thyroid problem gets referred to a doctor; panic attacks that render someone speechless to a psychiatrist or psychologist. Yet they may well be connected and have the same root cause: a blockage in self-expression, arising from a childhood trauma, connected with the throat area, and developing somatically into a chronic condition. This sort of approach, or more holistic perspective, is beyond dualism; it is un-Cartesian, and therefore outwith the realm of most of current science. Much of science is an attempt to reduce a situation

down to one of two measurable factors to assess the impact of changes. It is essentially a reductionistic, systemic approach, especially when applied to the body. If there's nothing wrong with your blood; or your heart; and your problem is not endocrinal; then it must be psychological (we have seen this sort of thinking around ME, CFS or PVFS[38]) – and this is scientific? *Reductio ad absurdum!*

Contradictorily there are well-established theories that the universe is organised along holographic principles, similar to those in the brain. David Bohn, a renowned physicist and protégé of Einstein's, has developed his theories and in the late 1970's proposed a space-time continuum that not only contains everything, but where each past also contains a representation of everything else, and all is connected. The energies of this system are both subtle and tremendous. Significantly, this only exists in material form when it is observed. He argues, *"that our current way of fragmenting the world into parts, not only doesn't work, but may even lead to our extinction."* (Talbot, 1996) These new 'scientific' theories have to have a huge impact on our perceptions of the world and our selves.

There are other non-scientific factors involved with these arguments as well. One of them is much more political and economic. Essentially there is a lack of work, as (in Europe) there are many unemployed or under-employed psychologists. (Americans, please understand that, here in Europe, the practice of psychotherapy is NOT dependent on having a

[38] ME: Myalgic Encephalomyelitis, CFS: Chronic Fatigue Syndrome, PVS: Post Viral Fatigue Syndrome, are all the most common names given to a variably debilitating disorder or disorders generally defined by persistent fatigue unrelated to exertion, not substantially relieved by rest and accompanied by the presence of other specific symptoms for a minimum of six months. Other symptoms include musculoskeletal pain, sleep disturbances, impaired concentration, and headaches. Almost every aspect of CFS is the subject of disagreement and uncertainty – even diagnosis. There are no characteristic laboratory abnormalities to diagnose CFS, so testing is used to rule out other potential causes for symptoms. When symptoms are attributable to certain other conditions, the diagnosis of CFS is excluded.

The absence of well-defined biomarkers coupled with an ability to point to a single somatic cause (e.g. an infectious process) has had a devastating effect on the way patients with CFS/ME are diagnosed, treated and regarded. Even though CFS/ME is now widely regarded as a "real" disease, the most popular explanation for this illness remains that it represents an extreme form of "medically unexplained illnesses." As such, many psychiatrists have speculated that the condition is the product of maladaptive behaviors, failure to self-regulate, or any of dozens of others profoundly psychological or behavioral causes. Adapted from The Marshall Protocol Knowledge Base (www.mpkb.org): accessed 4/6/12.

psychology Masters degree, or a PhD, as is the prevailing model in USA.) Perhaps there is a natural inclination to dislike someone 'poaching' on the territory that has been considered the province of clinical psychology. The British Psychological Society introduced a new category of counselling psychology a few years ago, coincidental (perhaps) with the growth of the UKCP. Was this a natural reaction to an increased or wider demand? Was it the discovery of a new field? Or was it their attempt to carve out a bit more of the existing field before the new entrants get too firmly settled in possession of the territory?

It could also perhaps be argued, even more forcibly, that psychologists have overlong encroached into the territory of what naturally belongs to psychotherapists, and that much of psychology training (outside of the clinical psychology module) has little or no components that in any way qualify those sorts of psychologists to work with clients whatsoever. If legislated on, this could or would free up a number of clients for the new psychotherapists. However, this struggle over territory and markets is not a scientific argument. We are not debating about the genus, or species, or sub species. We are not arguing about, or struggling to determine, the exact sequence of chemical or proteins in one part of the human genome (before anyone else). We are considering available demand and supply, the prevalent power-bases, and the impact any changes might have on our pockets.

Can we therefore conclude that if psychotherapy is not fully a science, filled as it is with dichotomies, uncertainties and unknowns, how can psychotherapy – the practice of this non-science or incomplete science – be a science, or indeed even aspire to be scientific?

A definition of psychotherapy

We would like to make a declaration here: Psychotherapy is more of an art, a skill, or, rather, a craft. It is a set of particular skills, specific to a certain field. Please consider that thought for a moment: consider psychotherapy (perhaps) more like architecture – the craft of building design – or interior design. It can obviously be 'informed by' science, and it can perhaps even 'inform' science (through its clinical results), but it is not in itself, and certainly not yet, a proper science. This latter point is argued very well (van Deurzen & Smith, 1996). It is stated that psychotherapy is not a science, at least not yet. It will be perhaps 50 years before it can be called a science, but it will be based on

very different parameters than at present, and then we may also need a new word – a 'logus' (-ology) word perhaps.

Gill Edwards (1992) argues that there are many new and significant paradigms that inform psychotherapy, rather than a science like psychology. These tend to put psychotherapy into realms where present-day 'science' does not yet operate. Psychotherapy is beyond science for the moment. Areas such as 'restoring meaning and significance in one's life', 'recovering a sense of … humanity, or of connectedness, of authentic power, of wholeness, of spirituality', are what psychotherapy clients are often interested in and, in their own words, this is what they often benefit from in psychotherapy. These are the reasons that they come. And these are far-and-away beyond simple measurements of pleasure or happiness.

We are an emerging profession. In Europe, (according to the 1990 Strasbourg Declaration on Psychotherapy), this is a distinct profession. We are squeezing ourselves into a field often dominated by medical professionals (psychiatrists) who see themselves as scientific, and academics (psychologists) who would like to see themselves as scientific. We do not have to play the same game, or buy into this paradigm. We can and should be different, and we need to establish what these differences are.

The craft of psychotherapy

We have stated in the title that we consider the practice of psychotherapy to be more of a craft; similar to that (perhaps) of general medical practice, or perhaps of an architect, or a lawyer (advocate). The main part of the practice exists where and when there are essentially just two people in a room, in a one-on-one relationship, with one person seeking information, advice, and help from another. Within medicine and law (in a similar situation), there is often a high level of distress on one side, and an awareness of personal and professional limitations from the other. There is an essential relationship between the practitioner and the seeker; the doctor and the patient; the healer and the 'to-be-healed'; the professional and the client seeking their services. What happens is that the professional relationship between them is developed, essentially for the benefit of the non-professional. If it develops 'badly' according to the client's expectations, the client, or patient, or seeker, will not be healed, or be served, may well feel disgruntled, and eventually go elsewhere. If it develops 'well', the client or patient will, after a period of

'treatment' or 'service' or 'therapy', hopefully not need an extension to that relationship and will have achieved their goals to their satisfaction. The aim of the relationship will have been hopefully (largely) fulfilled. Much therefore depends on the skill of the practitioner, be they doctor, psychotherapist, lawyer or healer; and it is their responsibility to serve this relationship.

The main instrument of psychotherapy is the psychotherapist himself or herself; using the complex possibilities implanted in an individual to perceive others, to detect as systematically as possible general mechanisms that help that person, and then to add to this through a series of repetition experiences. For the moment, science is not really capable of creating instruments that can detect the full range of signals that a human organism can react to. But the capacities of the human organism to detect miniscule inflections in facial, non-verbal, and emotional signals, minute details of behaviour, their possible meaning, and their place in a given context, is extraordinary. This is not an automatic process. It can be 'switched off' through ignorance, inattention or ego-distortion; and it can be refined and developed through training, experience and intuition. It is because we are learning to use ourselves as instruments of 'research' that we become able to perceive aspects of human behaviour and their 'signals' in such an incredibly refined way. But it has not been really conceived that individuals have to be used as research instruments; have to produce helpful behaviours, interjections or suggestions on demand; and that psychotherapists would have to help each other constantly in their endeavours: it is essentially still just a one-on-one relationship serving the needs of a client and dependent upon the skills of the practitioner. The development of procedures within psychotherapy is not just giving the patient tests; or testing hypotheses; or performing experiments; or putting the patient through 'processes'; instead we gain 9insights and improve our skills with that individual through a sophisticated form of (often non-verbal) feedback from the client.

Emmy van Deurzen (1996) also speaks of psychotherapy as a craft, though she wants to see it transformed into a *"scientifically based accountable professional expertise"*. She sees that psychotherapy has subsumed some of the 'mothering' functions in society and postulates that the opponents to psychotherapy are involved in a patriarchal reaction to increasing female power. For these reasons, she asks, *"How can we transform what was once the craft of motherhood into something that is more like science?"* But is

this not buying into the dichotomy between art and science? One could apply a similar argument as well to the perspective that psychotherapy has also subsumed some of the aspects of 'guidance' or 'mentoring' or 'spiritual healing' or 'education in emotional intelligence' that previously were carried by the Church or by the guild apprenticeships or by 'fostering' or by other societal means.

Difficulties in assessing psychotherapy

"Treatment" within the mental health profession has included, over the course of time, scalding baths, high-pressure, cold-water jets, the prolonged use of restraints, lobotomies, insulin shock, toxic narcoleptics, and electric convulsion therapy. Who is it that decides whether this or that treatment has been 'effective'? It is often the self-advertised practitioners of the particular techniques and they have a biased belief in their own techniques. Incidentally, we also see something similar today with research studies paid for, overtly or covertly, by the drug companies that 'assess' the effectiveness of their drug. So extreme care needs to be taken when reading such assessments, however 'scientifically' they are stated. Additionally, it is well known now that the observer can change the conditions they are studying by their mere presence. There are profound social biases about mental health that can distort any observations (Foucault, 2001). These have all been seen as arguments 'for' scientific demonstration. They can equally well be used to show that any so-called scientific demonstration may well be, and often is, potentially totally invalidated.

Psychotherapy does not lend itself well to the traditional randomized & controlled trial (RCT) that is the 'gold standard' of 'science'; nor to the 'double-blind' study that is used, for example, to test the efficacy of drugs. These are anyway not always infallible for drugs, as the thalidomide affair, and similar, more recent, incidents (e.g Vioxx) have shown. These have also highlighted serious flaws in the present procedures, as well as some fundamental concerns about this particular method of testing (Science Daily, 2008). When applied to psychotherapy, how do you give someone a psychotherapeutic *placebo*? Talking with someone (but who) over a cup of tea? Or do you refuse them treatment? Or do you use the 'absenters' (non-participants) as a control? Or what? The reduction of presenting symptoms is often a necessary requirement for something to be considered as a 'cure'. But what happens if

both the therapist and the client have a vested interest in 'demonstrating' that the symptoms have been reduced: the therapist to demonstrate his efficacy; the client for (perhaps) transferential reasons. All of these factors can and do seriously distort scientific observations.

By trying to fit a round peg into a square hole, we are actually creating problems for ourselves. The 'scientific' criteria often simply do not apply to psychotherapy. It is much more of a skill or a craft, and so let us sit with this and relax in this space, instead of desperately trying to 'prove' our scientificity. And to what end? Why can we not – legitimately – be the 'skill-full' arm of the mental health profession? Then we would have to use a different form of 'science' to demonstrate our efficacy.

Definition of symptoms

Within general medicine, the 'symptom' is usually quite closely linked to a particular medical problem. There is a natural, traceable – sometime causal – relationship, and the symptom is a fairly concrete one, and it doesn't necessarily change until the 'problem' goes away. For example: persistent dyspepsia and/or upper abdominal pain after eating, belching, heartburn, feeling bloated, sick or vomiting are symptoms of a peptic ulcer. The most common cause is infection of the stomach with bacteria called *Helicobacter pylori or H. pylori*. This infection is quite common; and about half of the world's population is so infected. These bacteria cause the stomach to make too much acid, which damages the lining of the stomach or duodenum and this causes the ulcer. Some medicines, called non-steroidal anti-inflammatory drugs (NSAIDs), can also cause peptic ulcers. Smoking and drinking can increase the likelihood of such ulcers, but excessive stress – by itself – has not shown to be a cause. Peptic ulcers used to be 'treated' by a number of antacid concoctions poured down the throat in ever-increasing quantities. But this was – actually – just the treatment of the symptoms, whereas a simple antibiotic, targeted at the *H. pylori* bacteria, clears the source of the problem up permanently.

Many of the problems that we find in psychotherapy have an artificial relationship with the symptoms, and these are not absolute ones: they change. We have personality traits and 'states' of depression and anxiety: they tend to come and go: less prevalent at one time, more so at others. This is very different from (say) an ulcer, even though there can be degree of worsening on a temporary basis. Furthermore, the categories of symptoms that we might

ask scientists to study in psychotherapy are not fixed. Wittgenstein started this argument with his 'family resemblances': the definition (and labelling) of schizophrenia has changed through the ages: the APA voted (yes, actually voted) at one point that homosexuality was no longer to be classed as a mental illness; people in the anti-psychiatry movement, like Thomas Szasz, Michel Foucault, Cleckley, Faber, Pridmore and others, regard the psychiatric categories (DSM IV, etc.) as methods of determining which types of behaviour are socially unacceptable at any one moment. The controversy over DSM-V is even greater. And yet placement into a particular category is now necessary in order to receive payment or remuneration from the insurance companies that are increasing controlling the treatment of mental illness (at least in America). Some diagnoses, prevalent in the West, are not found in other societies like India or China. The relatively recent advent of neuroscience has open up a huge new range of information that is radically changing our perceptions of what happens to people with certain conditions (viz: MRI scans show the amygdala of people with PTSD has been over-'triggered': Burdick, 2001)

What all of this means is that there is little or no fixed basis for a scientific study of symptoms, nor a really clear determination of psychotherapeutic symptoms, and any such determinations are relatively arbitrary and liable to vary. This means that any form of comparison of patients and equations between symptoms and treatments is probably going to be equally arbitrary. Peoples' reactions to a particular form of treatment vary considerably, and the same psychotherapeutic 'treatment' will vary when applied by different psychotherapists. This almost fatally undermines any chance of a truly 'scientific' study.

Determining factors

There are three generally agreed factors in determining mental illness, or the lack of mental health, in a person. These characteristics are: (**1**) the observance of dysfunctional or maladaptive behaviour; (**2**) the individual experiences a degree of suffering and lack of ability or achievement; and (**3**) the individual's behaviour is derogated by others. Diagnostic manuals concentrate on the first. Clients come to therapy because of the second. Critics focus on the third. Exclusive reference to any one of these is probably inappropriate and unhelpful. However, all three depend on sets of symptoms and possible scales,

ranges, degrees or spectra within a particular symptom. So psychotherapists need to be familiar these characteristics and the symptoms within them, but without necessarily focussing on any single characteristic. We are more focussed on dealing with a whole person: a synthesis of a huge number of different aspects, with an evolving history and latent potential: we need to be able to take in the whole 'gestalt'. This 'holistic' view suggests a high measurement of skill and (possibly) a higher level of training than is currently required, with a relative level of independence from the insurance companies and attendant 'psychiatric' diagnostics, and even (if possible) a degree of distance from our social conditioning.

Social effects of psychotherapy

We are faced with some chronic problems, as we become aware of the very real problems that people are facing, and suffering from, and particularly what social factors create these problems. There is a whole mass of very hard data that confronts us: we have the potential beauty and the horror of human interactions; we have the increasing impacts of climate change, social inequalities, globalisation, economic realities – and these impact, implicitly and sometimes overtly, on our practice and on the therapeutic relationship with our clients. As professionals, we could and (perhaps) should, take a stand on some of these issues. It is not as if we are unaffected. But, do we change our fees when there is economic hardship and the people who have been seeing us for a certain number of months and years are suddenly crippled by a higher mortgage, devastated by redundancy and/or a much lower income, or even faced with the repossession of their home by an avaricious bank?

We have to hear their horror stories; we have to swallow our own horror. These items of data are very important and perhaps should not be 'kept' within the sanctity of the therapy room. We cannot break confidentiality, but we can – and should – speak out: in seminars and conferences, in case histories, in articles, and in simple (research) studies. Otherwise issues like childhood sexual abuse, or domestic abuse would never have come out of the closet. This data has to be made quite widely known; otherwise the wider society that we all live in cannot absorb it and change appropriately.

Society has to be made aware that it is repressing sexuality, or individuality, or (in some cases) freedom, and (in other cases) certain classes or races or religions or sections of the population – like elders, farmers, immigrants, etc.

and come to learn to *know* that it is repressing these aspects, and *how* it is repressing these aspects, and maybe even *why* it is repressing these aspects. It is only people in the human sciences (psychology, psychotherapy, sociology, etc.) and people who have direct contact with those suffering (doctors, social workers, psychotherapists, counsellors, etc.) who really know about these aspects. Society also needs to be made aware that some of the silent minorities (children, women at home, immigrants, prisoners, etc.) can have a voice, should have a voice, and that they only way they can be heard is (perhaps) if we encourage them, assist them, or (initially) even speak for them.

Psychotherapy can have an extremely important political function – if we allow it. It needs to be aware, or made aware, that is the societal traumas are not treated, they usually cause greater problems. Much work has been done recently on realizing, for example, the effects of post-traumatic stress disorders, and, more relevantly today, that people who are seriously traumatized (e.g. refugees recently arrived in Europe) cannot make sufficiently adequate statements about the situation in their home country if they are still traumatized, and then they will stay traumatized. Yet they may be forced to make such statements within a few weeks of landing in an alien culture, or else they get deported back to their country of origin,, and back to the horror they have fled from.

Some psychotherapists actively go into areas of conflict, like the Balkans, to work with traumatized and terrorized populations: a little bit like *Medicins sans Frontiers*. This is excellent work and not everyone can do it. It is psychotherapists (and the people they listen to) who can inform us – for example – that babies really need to be touched, and some of the detrimental effects of not touching and (particularly) of not being touched as a baby: or the detrimental effects of being touched inappropriately, or of being sensorially isolated; or of being smothered; or of binding and swaddling (which still happens in some Eastern European countries; or of the subsequent benefits of restorative or healing touch (Field, 1999).

There are often huge issues of traumatisation experienced by women in these areas, as continuous rape (and subsequent impregnation) are increasingly being used as weapons of war, ethnic cleansing, and of social control and discrimination.

As professional psychotherapists, we are, can be, or should be, a main source of information on a whole number of wide-ranging social issues, and

we can further work to be one of the significant protagonists of change in society. The very hard data that can emerge from properly conducted and recorded clinical work can alert others to the problems in the society. When enough people become aware of the 'problem', researchers can investigate more fully, articles can get written, studies can get conducted, pressure groups can form, and social change can start to happen. This is the way society can be changed, and does get changed.

It is psychotherapists who often first become aware of some of these issues, and it is the role and duty of psychotherapists to inform the scientists, the sociologists, the politicians and legislators that there is something here that needs investigating. The psychologists and the social anthropologists can do the research that will either support the psychotherapist's findings or concerns, or dismiss them. But this type of research is not the role of the psychotherapists, and neither are they (currently) trained to do this. We can work together with other professionals.

Similarly, psychotherapists may also become aware of an ecological or environmental issue, or there may be an aspect of a spiritual function (like reincarnation, out-of-body or near death experiences) that needs further exploration and research.

Training and research

As mentioned, there have been a number of well-known studies about the efficacy of psychotherapy. If we use science to inform us about psychotherapy, we get some interesting findings. Smith and Glass (1977) summarized 375 diverse studies (later extended to 435) in a meta-analysis. The results fairly conclusively demonstrated first that psychotherapy is quite effective (which is borne out by other studies) *and*, second, that the credentials and experience of psychotherapists are unrelated to any patient outcomes, however those are determined. These have also largely been borne out by other later studies (Strupp & Hadley, 1979; Miller & Hester, 1986; Crits-Christoph et al, 1991). One study found fewer therapy drop-outs with more experienced therapists (Stein & Lambert, 1995). Another meta-analysis concluded that:

> Decades of research indicate that the provision of therapy is an interpersonal process in which a main curative component is the nature of the therapeutic relationship. Clinicians must remember

> that this is the foundation of our efforts to help others. The improvement of psychotherapy may best be accomplished by learning to improve one's ability to relate to clients and tailoring that relationship to individual clients. (Lambert & Barley, 2001)

However, I would also like to quote from the abstract of another research article (Persons, 1991):

> It is argued that the design of contemporary psychotherapy outcome studies is conceptually incompatible with the models of psychotherapy evaluated in those studies. Contemporary outcome studies are incompatible with psychotherapy models because the outcome studies treat patients with standardized treatments that are assigned on the basis of psychiatric diagnosis rather than with individualized treatments based on a theory-driven psychological assessment of the individual's difficulties. One possible remedy, idiographic outcome studies using a case formulation model of assessment and treatment, is proposed here. It is suggested that this research strategy may narrow the scientist-practitioner gap and make it easier to demonstrate differential outcomes of different treatments.

Further studies (Frank, 1973; Strupp, 1989) also conclude that the efficacy of psychotherapy depends on 'non-specific effects', like the quality of the therapeutic relationship. Katherine Mair (1992), in an excellent article examines much research and concludes that whilst psychotherapy can be a valuable means of helping people, its efficacy is not due primarily to the models and methods it uses. This is clearly not scientific. However, politicians, health 'experts', policy makers, and people who are setting the 'guidelines' for non-pharmacological treatments for depression and so forth are continually ignoring these sorts of results: they do not want to know this sort of information as they cannot plan properly, or control the profession, or recommend treatments. This is not scientific.

When we look at the types of studies that abound, there is often a scarcity of funding for these. Unlike medicine, psychotherapy does not have large institutions foundations, hospital and university research departments, support groups for research in to a particular disease, and so forth. Many

of the claims for funding need to hint at a new 'discovery' or 'technique' in order to attract funding. This is doubly spurious as it also creates a climate of thinking that there actually is a new discovery or technique out there, waiting to be found. This is not scientific.

Added to this is another major factor: as mentioned, most psychotherapists (at least in Europe) are not properly trained in scientific research: their training is much more experiential. This means that much of the research in psychotherapy – if carried out by psychotherapists – is not particularly good science: therefore most good research in psychotherapy is actually carried out by psychologists. This creates a distortion. And whenever these research findings get published, the level of discriminatory expertise amongst psychotherapists is often insufficient to determine whether the research is good or mediocre or otherwise; thus 'bad' results can easily get passed on. This is not scientific.

Now, if psychotherapy is a skill, an art, or a craft, like general medicine, architecture, or advocacy, we suddenly find a much more beneficial climate. A lot of the problems disappear. But this does not mean that psychotherapy has to reject science. There is a very fruitful – potential – relationship whereby psychotherapy can be informed by science and can even – in turn – inform science. But the main point has been made. Psychotherapy is not a science, and it is not (yet) scientific. We have illustrated one or two ways how it can inform science. The developments of neuroscience, research studies in psychology and sociology, all can and do inform psychotherapy. There can be a cooperative relationship. Psychotherapeutic skill is essential and necessary to the practice of clinical psychology. Psychological research is essential and necessary to psychotherapy. In the distinction and difference, there are many benefits: seeing psychotherapy as 'scientific' just creates confusions.

Predictability

One of the functions of a science is also the ability to predict: and this – perhaps – is one of the main reasons for the 'political' pressure on psychotherapy to be 'scientific'. Psychotherapists claim that they can understand other people. These two often get confused. Psychotherapists sometimes try to predict: this can be very dangerous. It might make good television (e.g. *Cracker*) and nowadays there is a greater level of science in predicting issues around certain pathologies, like serial killers. But success as a psychotherapist

depends primarily on the personal (empathic) quality of the therapist and how they relate to a client. However, it is then necessary for the client to be sufficiently motivated to take action and make significant changes to his/her life and/or thinking. Psychotherapy is not a simple cause-and-effect whereby an injection of (say) vitamins, antibiotics or cognitive therapy will have a fairly high change of working, thus creating an assessable level of predictability.

But we find that psychotherapists and psychologists are going into courts and onto media news and shows continually providing scientific opinions and explanations as to aspects of human behaviour. Their claim is that psychotherapy leads to understanding. This may be true in general, but is not true for the individual. Individual humans are, in this respect, more like individual photons and particles: it is impossible to predict their next move. However, it is possible to predict statistically overall movements. Again the situation is not helped by TV shows (like *Cracker*) where a super forensic psychologist predicts the psychotic criminal's next move. This is based on the false assumption that expert clinicians (and we need to be cautious about these) have an expertise similar to a medical diagnostic specialist. This is not so. Medical diagnosticians have a vast amount of direct feedback to build their expertise on, in the form of positive and negative test results. Clinicians do not have such a range of experience, not such a form of direct feedback. We should be very cautious of pseudo-science as it relates to psychotherapy.

If we examine studies that compare actuarial (statistical) predictions with clinical predictions, we can see that there is little basis for any degree of predictive ability for clinicians. Meehl (1954, 1996) demonstrated this for psychology, as did Goldberg when he compared clinical assessments with MMPI profiles: however *"the Goldberg rules are probably best thought of as a means of classifying large groups of patients or profile types rather than a way of classifying individual profiles"* (Friedman et al, 2001, p. 464). Furthermore, much is made of the personal contact that happens within a clinical setting, but many studies of assessment based on interviews shows that this is also a very unreliable predictor. This is a very unpopular finding and professional bodies like the APA disavow some of these studies, but they cannot fully discredit them.

When we consider another assumption, that the accuracy of psychotherapist's judgement increases with their clinical experience, we can find studies that

show that this is not the case. Instead, we may learn from experience, as is suggested by Patrick Casement's excellent books (1985, 1990) and which are a refreshing look at the 'myth' of the professional's infallibility. But the accuracy of judgement depend s first on the accuracy of the technique. Some techniques, such as the Rorschach Ink Blot Test, though widely used, are not accurate and have been proved so. Add to this factors such as selective recall, selective interpretation, and previously formulated assumptions; psychological factors that are often used to discredit witnesses in court by opposing psychologists, and we find them here capable of being used against those psychologists. Garb's (1989) study summarized that professional clinicians make somewhat better judgements than do non-professionals, but not statistically significant ones, and these can be explained by differences in intelligence and familiarity with particular techniques. A later summary stated:

> In conclusion, we know of no evidence that indicates that more than a few academic clinical psychologists believe that little or nothing can be learned from clinical experience and practice. Although we agree that important ideas can be generated from clinical practice and experience, we encourage clinicians to become familiar with research on the limitations and strengths of clinical judgment. (Garb & Grove, 2005)

Faust *et al* (1988) concluded that: *"no systematic relations were obtained between training, experience and accuracy across a series of neurophysical judgements."* It therefore seems that there is little 'scientific' basis for any form of diagnostic ability; and if that is missing, there is a gaping hole in the centre of the scientific argument.

As we start to formulate a new profession of psychotherapy in Europe, we make a plea: let us, in Europe, not fall into the trap that the mental health professions and psychology in America have fallen into. They have based their claim for a profession on a scientific basis, yet most of the scientific studies do not favour the psychological professions. There is little certainty about treatment; there is little scope for properly 'scientific' studies; there is little value in experience; there is little correlation between diagnostics. There is also an almost complete dominance by the insurance companies and an increasing pressure from them to determine treatment on the basis of cost, not need: thus for this DSM-IV diagnosis, they will pay you for a certain

number (x) of sessions; but for a slightly different diagnosis – possibly with the same patient – they will pay you for a different number (y) sessions: all this based on their scientific studies and statistics of efficacy.

So why are we involved with science? Maybe it is because we wish to claim a slightly higher respectability alongside other loner-established professions, and we are using 'science' – the God of the Modern Age – as a label of that respectability. It seems a pity that we can undermine our greatest asset and promote our weakest one in order to gain such acceptance. So we can conclude this section with the concept that science can inform psychotherapy and we hope that we have demonstrated that psychotherapy is not really a science.

Registration and legislation

There is also the very contentious issue of licensing psychotherapists: most professionals have a professional body or association or are registered or licensed in some way or other. There are three basic types of professional license. The first type is a voluntary register whereby an accredited psychotherapist (like one with the ECP) becomes accredited by other similar professionals and can work in any country where there is not a particular law or restriction: his or her accreditation is thus generally accepted as a mark of quality both within the profession and by the public. The second type of licensing is where a particular country or national body decrees that you cannot call yourself a 'psychotherapist' without having done this or that: the name of 'psychotherapist' is licensed. This applies to professions like a lawyer or an engineer: you cannot call yourself a 'qualified' professional without being on a national or state register, and this is 'managed' by a government body. The criteria of this statutory register may be identical to that of the voluntary register, but it is more state-controlled. This is usually justified to ensure the 'public interest'. The third type of license is where the *practice* of psychotherapy (in this case) is licensed and thus limited only to people who are on the register. This is the case for doctors, dentists and vets: no-one can practice these professions without having done this and that and the other and without being properly on the register. The state (or the professional body acting for the state) can also take you off the register and thus stop you from practicing: the ultimate control, usually only applied in professions where an unlicensed person can do considerable and irreparable harm. Any form of de-registration is usually only done after a serious transgression:

again it is stated to be in the public interest to ensure that unqualified people do not endanger people. It is unlikely that this third type will ever be applied to psychotherapy. This is not to say that we are against high standards, generally applied, but we are also quite unsure about the appropriate level of licensing. Should we also license sculptors and artists; or only architects and lawyers?

The usual rationale and most frequent argument given for licensing is that it is a way of ensuring high standards and protecting the client and the public. However, this applies almost equally to the first form, accreditation, as to the others – the only difference being in who checks the Register; so why is more strict licensing necessary? The members of the public involved are assumed not to be able to make informed choices when they are confused or 'out of their minds'. There have to be certain forms of protection or checking – so the argument goes. However, a member of the public wanting the services of a psychotherapist is probably as capable of making as informed a choice about a psychotherapist, even when in need of their services, as they are about which garage they take to in order for it to be fixed. They can choose an 'approved' Saab (or whatever) garage, or they can use the garage 'round the corner', or use a friend, or they can fix it themselves – if they know how. We must be very careful about analogies with medicine: we have already over-used them in this article, and now we are arguing against them. Most psychotherapists work with people in distress: but these people are not mentally ill, and many efforts have been made to de-stigmatize emotional distress and not confuse it with mental illness, against which there is a very powerful social paradigm.

Nor do psychotherapists (in Europe) provide people with drugs (unless they are qualified psychiatrists as well), nor do they practice surgical or invasive techniques on their patients. They provide a service to their clients for which they are paid, either by the client or (increasingly) by insurance companies and state health schemes. It may be some perceived pressure from these that is creating the demand for state licensure. If so, it should be resisted. This is a purely political argument (or power-struggle); it is one about who ultimately controls the profession; and we can win it or lose our independence. The situation in American is horrendous, and 'managed care' is an increasing imposition of form-filling, diagnostic codes, fee scales, and limitations on the extent f therapy according to the diagnosis. Psychotherapists now have

to employ special people to fill in the correct and complicated forms in order eventually to get paid.

There is another argument against licensing. Licensing regulates training. Training is usually a once-and-for-all, pass-or-fail situation. There may be some continuing education requirements, or some 5-year or 10-year reviews, but these are pretty limited in scope to only a few professional associations. Licensing does not regulate actual practice, other than require compliance with the profession's code of ethics. It is all reactive: nothing ever happens unless something goes wrong or there is a complaint. We have no objections to codes of ethics: we helped to write some of them. But there is little regulation of techniques. We know many people who, as a registered or licensed psychotherapist or clinical, actually practice techniques different to the ones they were trained in, some of which are not officially licensed, registered, recognized, evaluated or approved in any way whatsoever. Some of these techniques have their own training programmes, but usually outwith the universities or state boards. This is not a bad situation, as it encourages professional development, but it also cuts the bottom out the argument for licensing. Licensing involves a situation that possibly was valid 5, 10, 15 or 20 years ago; not a current situation – and there is no way that this situation can be effectively regulated without total control or intrusive monitoring. We also know of a number of medical doctors that practice homeopathy and other complementary health techniques with their medical patients. This can be seen as a useful adjunct, and is often less invasive than some modern pharmacology. But we also know that some of these doctors have not fully qualified in these practices and 'assume' that their medical training allows them to practice this technique more safely than a lay person – they are probably correct, but this does not give them a 'license' to practice these additional techniques. We are entering in quite cloudy waters.

Maybe the pressure for licensing psychotherapy comes not from without, but from within. Maybe it is a way of defining who we are, and reassuring ourselves how professional we are. It is also a way of excluding others who we don't like or want within the profession. It is a way of getting official recognition, and thus greater social prestige, and perhaps power. It is a way of discriminating, and also charging higher fees. Licensing is possibly really for our own benefit, and we probably need to be a lot more honest about this, and own this, as and where it is true. Only this way will we be able to

recognize this motive, as far as it extends, and not trap ourselves in a form of hypocrisy.

There is also a further danger with the pressure of licensure coming from within. Those already with power and position in the profession get to determine what we are, as a profession. Do we have enough experience and information about other modalities within the profession? How much personal therapy will be required? How much clinical experience is required? With how many clients, and for how long? How much theory do we do in our training? How much scientific training and basic research is included? How do we keep the profession alive and free from stagnation? What needs to change after 10 years? 50 years? 100 years? These are important questions, and not the only ones – and currently the only pressures directly on us are those coming from within the profession. We are doing this to ourselves, and we must take responsibility for everything that we do. There is already a significant branch of psychotherapy (psychoanalysis) that may split off and consider itself not as a part of psychotherapy; either because it doesn't want to, or because it cannot comply with the criteria already established by the rest if the psychotherapies, or because it wants to be seen as something quite special and different. Considerations have already been made for those types of psychotherapy (cognitive-behavioural, etc.) that have not previously required personal therapy, mainly because it does not fit with their 'construct' of therapy being only for those who have problems, but also the concession was made because this is a very large branch of psychotherapy, with many therapists and a high degree of acceptance. Again, we have political decisions being made; the arguments are about inclusivity and numbers; and these are not 'scientific' ones, or ones based in science.

There are arguments to discriminate between the different methods of psychotherapy, as to which are more appropriately scientific or not. Wilkinson (1999) argues for *pluralism*:

> Scientific pluralism is the only possible basis for a scientific psychotherapy; it is by definition the only genuine wide enough concept of method to admit a mutual appraisal of method in psychotherapy. For it is the mutual appraisal of method. …
>
> … if the whole field of psychotherapy is to establish itself upon a scientific basis, it can only be on the basis of pluralism. The dangers

> of any alternative are staggering. This is the only way in which the Strasbourg Declaration's commitment to both the assurance of multiplicity of methods (Article 3), and the status of 'scientific discipline' (Article 1), can be sustained. Otherwise the science being appealed to will turn out to be dogmatic positivism; it will be what David Boadella calls scientism.

This is a telling argument actually against any sort of scientific appraisal. However, the conflicting philosophies and politics within these arguments take us no further forward: they are still arguments about power, not really about science. Power-games undermine the whole field. There have been attempts by one country within the EAP to have its particular model adopted and thus imposed on all the others. There were also attempts for the National Awarding Organisations to dominate totally the awarding of the Certificate without any reference to any of the modalities (European Wide Accrediting Organisations) that are more largely responsible for the quality of the type of psychotherapy. Again, all of these are very political considerations. They depend on the power and influence of the various psychotherapies and the different countries involved. If we get the balance wrong, we can totally mess things up for ourselves for a very long time from here on down the line as we establish this new profession. Psychotherapy is perfectly capable of regulating its own house, deciding on how to treat its variations differently, and undertaking the requirements of a profession – without being scientific.

All this now has to be balanced within the context of a European-wide free labour market, which includes an inalienable right that, if you are qualified to practice in one country, you cannot really be prevented from practicing in another. There are now examples of cases brought by state boards or ministries in one country wanting (requiring) an immigrant psychotherapist to retrain that have come to court and have been thrown out as being against the free-labour market. This creates a difficulty for those countries that have already passed a 'psychotherapy' law that is particularly restrictive. The German, Dutch, and Italian 'models' (whereby psychotherapy is seen more essentially as an activity, or a technique, to be practised only by specially trained doctors and psychologists, are unlikely to be able to stand up to psychotherapists coming in from countries where psychotherapy is being

accepted more as an independent profession (UK, Ireland, Malta and some Scandinavian countries).

The latest development is for the EAP to apply to the European Union for something like a "common platform" on psychotherapy, or a European 'passport' for the recognition of professional qualifications. This would establish:

I The need for a definition that would clearly identify the profession of psychotherapy and differentiate it from any other profession that is close in nature or practice (eg: psychology, psychiatry, counselling).

II The need for a "platform" (or proposed compensations) that do not impose on migrant psychotherapists any more stringent demands than those that can be imposed by the Member States individually, based on the provisions of the Directive, i.e. an aptitude test, or an adaptation period of up to three years (according to Directive Article 3.1.g & h).

III A fairly comprehensive overview of the present 'status quo' in each of the member countries, so as to demonstrate the variety and variances and thus the potential need for a platform or a professional 'passport'.

IV The need to justify the presentation of a platform (or similar) through clear evidence that the current situation is unsatisfactory. (i.e there are situations where psychotherapists cannot cross borders easily).

V The need for the EAP to provide evidence of its degree of representation across Europe and across the various methods and modalities.

New paradigms

According to Prigogine & Stengers (1984), the central problem of Western ontology is the relationship between 'being' and 'becoming', and this they seem to share with respected philosophers like Whitehead in his *Process and Reality,* and Heidegger's *Sein und Zeit,* or Kuhn (1996). Most of classical science was an attempt to reach the timeless world of supreme rationality. But we are discovering a more subtle form of reality that involves games (not laws) and theories of irreversible processes. Herman Weyl (1949) states:

> Scientists would be wrong to ignore the fact that theoretical construction is not the only approach to the phenomena of life: another way, that of understanding from within (interpretation),

> is open to us … Of myself, of my own acts of perception, thought, volition, feeling and doing, I have a direct knowledge entirely different from the theoretical knowledge that represents the 'parallel' cerebral processes in symbols. This inner awareness of myself is the basis for the understanding of my fellow-men whom I meet and acknowledge as beings of my own kind, with whom I communicate sometimes so intimately as to share joy and sorrow with them.

Yet Western thought is still partially bogged down in the scientific paradigm of reductionism: the skill of dissectional analysis is still paramount. What we in the West are not so good at is putting the pieces back together again, and moving forward together. Science has had a strong tendency to try and examine what is ('being') and there is often a dissociation with time. The laws of science involving temporal changes ('becoming') are relatively new and have not fully permeated down into the culture that much. Yet this sort of perspective is much more appropriate to psychotherapy – if we are going to consider science in a proper relationship to psychotherapy.

Most of 'old' science has been concerned with mechanical, closed systems; with cause and effect; linear relationships; and equilibriums. The new sciences are involved with open systems; non-linear relationships; randomness; probabilities and chaos theory; fluctuating sub-systems; dissipative structures and feedback loops. Biological and social sciences fall much more into this latter category. It is these that we are studying and using to influence psychotherapy. We must therefore look much more at these new sciences for any validation, if there is one.

> It is hard to avoid the impression that the distinction between exists in time, what is irreversible, and on the other hand, what is outside of time, what is eternal, is at the origin of human symbolic activity. Indeed, one aspect of the transformation of a natural object, a stone, to an object of art, is closely relate to our impact on the matter. Artistic activity breaks the temporal symmetry of the object. It leaves a mark that translates our temporal dissymmetry into the temporal dissymmetry of the object. Out of the reversible, nearly cyclic noise level in which we live arises music that is both stochastic and time-oriented. (Richards, 1980)

Psychotherapy as a craft

Much of this article has been about why psychotherapy is not a science, or what goes wrong we consider it as a science, or with scientific parameters. We have also suggested that there may be some way forward with newer interpretations of science. We would now like to consider psychotherapy as a craft: some of the arguments have been already put implicitly. Yet this is not necessarily a strict duality: i.e. if it is not a science, it must be a craft.

Earlier we suggested that it is a craft that can be informed by science, and can inform science. Let us consider the Arabian and Japanese sword-makers of the Middle Ages. Often they made their swords for a particular person. Some of their swords still exist and have been scientifically analysed: the steel has been heated and hammered, split and folded back upon itself many times and then re-welded to create a complex structure of many thousands of layers. Even with this sort of analysis, it is still extremely doubtful whether their techniques could ever be repeated today. They are extremely beautiful and still carry an edge after hundreds of years. Science, or art, or craft? Let us consider as well, the 'art' or 'craft' of the general medical practitioner: often a local man or woman, well-trained, but practising no speciality except general medicine, focussing on the individual needs of their patients. This is not a science; yet s/he uses science, and can often inform science. Let us further consider the craft (or art) of an architect. Certainly s/he needs to be informed of new materials, their strengths and properties, and ways in which they can be used. Certainly there is a science of people movement, use of light, energy conservation, ergonomics, proportion and perspective, the combination of materials, and other forms and techniques; but no-one seriously considers an architect as a scientist, or architecture as a scientific study. It is an art form, or a craft.

Psychotherapy falls within this definition of a craft; much more than within the scientific realm. Let us be content with this. Let us resist attempts to over-control it, for possibly spurious reasons. Let us maintain our skill, our love, our compassion, our sense of beauty, or compassion, our intensity, and our capacity to let go and let be what is ready to change of its own accord. Let us work to make ourselves as redundant as quickly as possible so that we can go onto something new; and, if the situation demands it, and only if the situation demands it, let us also have the clarity and determination and persistence to stay with these, giving our all until the job is done.

These are the marks of a craftsman, with no disrespect for the female members of the guild. We are shapers. We assist others in the journey of their soul. We sometimes help them to heal the wounds that have not yet healed. We apply rigorous criteria to ourselves – and this is good. This helps shape us. We cannot go with others where we have not gone ourselves – and this is good. This helps shape us. We cannot go with others where we have not gone ourselves, or where we are not prepared to go ourselves. Our work, our craft, marks us too. We cannot practise these skills effectively and be unmoved. Psychotherapy is a craft, not a science!

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References

Backster, C. (1968) "Evidence of a Primary Perception in Plant Life." *International Journal of Parapsychology vol. 10, no. 4, Winter 1968, pp. 329-348.*

Burdick, D.J. (2001) The Neurobiology of Fear: Emotional Memory and Post-Traumatic Stress Disorder. (Retrieved 02.01.09 from http://serendip.brynmawr.edu/bb/neuro/neuro01/web1/Burdick.html#1)

Casement, P. (1985) *On learning from the patient.* London: Routledge.

Casement, P. (1990) *Further Learning from the Patient: The Analytic Space and Process.* London: Routledge.

Collinge, W. (1998). *Subtle Energy: Understanding the Life Force Energies that surround us.* London: Thorsons: HarperCollins.

Crits-Christoph, P., Baranackie, K., Kurcias, J., Beck, A., Carroll, K., Perry, K., Luborsky, L., McLellan, A., Woody, G., Thompson, L., Gallagher, D., Zitrin, C. (1991) Meta-Analysis of Therapist Effects in Psychotherapy Outcome Studies. *Psychotherapy Research, Vol. 1, No. 2, pp. 81 – 91*

Davidson, J. (1987). *Subtle Energy.* London: CW Daniel: Random House.

Dawes, R.M. (1994) *House of cards: psychology and psychotherapy built on myth.* New York: Macmillan.

Edwards, G. (1992) *Does psychotherapy need a soul?* In Dryden & Feitham (eds) *Psychotherapy and its discontents.* Oxford: Oxford University Press.

Faust, D., Guilmette, T.J., Hart, K., Arkes, H., Fishburne, F.J. & Davey, L.

(1988) Neuropsychologists' training experience, and judgemental accuracy. *Archives of Clinical Neuropsychology, 3, 145-163.*

Field, T. (1999) *Touch Therapy.* Amsterdam: Churchill Livingstone.

Foucault, M. (2001) *Madness & Civilisation. (2nd ed.)* Hove, Routledge.

Friedman, A.F., Lewak, R., Nichols, D.S. & Webb, J.T. (2001) *Psychological Assessment with the MMPI-2.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Frank, J.D. (1973) *Persuasion and healing. (2nd. Ed.)* Baltimore, MD: John Hopkins University Press.

Garb, H.N. (1989). Clinical judgment, clinical training, and professional experience. *Psychological Bulletin, 105, 387–396.*

Garb, H.N. & Grove, W.M. (2005) On the merits of clinical judgement. *American Psychologist, Vol. 60, No. 6, pp. 658-9.*

Gerber, R. (2001). *Vibrational Medicine: The Number 1 Handbook of Subtle Energy Therapies. 3rd Ed.* Rochester, VA: Bear & Co: Inner Traditions.

Gibson, J.J. (1986) *The Ecological Approach to Visual Perception.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Giorgi, A.P. (1970) *Psychology as a human science. A phenomenologically based approach.* New York: Harper & Row.

Goldacre, B. (2008). *Bad Science.* London: HarperCollins.

Horowitz, K. A., Lewis, D.C. & Gasteiger, E. L. (1975) Plant primary perception. *Science 189: 478-480.*

Kepner, J. (2003). Energy & The Nervous System in Embodied Experience. PDF: available as a download (22/01/11): www.pathwaysforhealing.com/resources-articles-and-information

Kmetz, J. M. (1977) A study of primary perception in plants and animal life. *Journal of the American Society for Psychical Research 71(2): 157-170.*

Koch, S. & Leary, D.E. (eds) (1985/1998) *A century of psychology as science.* Washington, DC: APA.

Lambert, M.J. & Barley, D.E. (2001) Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training: Vol. 38, No. 4, pp. 357-361.*

Lemaine, G. & Matalon, B. (1985) *Hommes supèrieurs, homes infèrieurs."* Paris: Armand Colin.

Mair, K. (1992) The myth of therapist expertise. In Dryden, W. & Feltham, C. (eds) *Psychology and its discontents.* Oxford: Oxford University Press.

Meehl, P.A. (1954, 1996) Clinical vs. Statistical Prediction: A Theoretical Analysis and a Review of the Evidence. New York: Jason Aaronson.

Miller, G.A. (1985/1998) The constitutive problem of psychology. In Koch & Leary, pp 40-45.

Miller, R.W. & Hester R.K. (1986) Inpatient alcoholism treatment: who benefits? *American Psychologist, 41. Pp. 794-729.*

Oschman, J.L. (2000). *Energy Medicine: The Scientific Basis*. Edinburgh: Churchill Livingston.

Persons, J.B. (1991) Psychotherapy outcome studies do not accurately represent current models of psychotherapy. A proposed remedy. *American Psychologist, 46, 2, pp. 99-106.*

Prigogine, I. & Stengers, I. (1984) *Order out of chaos: Man's new dialogue with nature*. London: Bantam.

Richards, R.J. (1980) Wundt's early theories of unconscious inference and cognitive evolution in their relation to Darwinian biopsychology. In Bringmann, W. & Ryan, D.T. (eds) *Wundt studies: A centennial collection*. Toronto: C.J. Hogrefe.

Smith, M.L. & Glass, G.V. (1977) Meta-analysis of psychotherapy outcome studies. *American Psychology, 32, 9, pp. 752-760.*

Science Daily (2008) Toxic drugs, toxic system: Sociologist predicts drugs disasters. Retrieved 2/1/09: http://www.sciencedaily.com/releases/2008/08/080804100304.htm

Stein, D.M. & Lambert, M.J. (1995) Graduate training in psychotherapy: Are therapy outcomes enhanced? *Journal of Consulting and Clinical Psychology, Vol. 63, 2, pp. 182-196.*

Strupp, H.H. (1989) Psychotherapy: can the practitioner learn from the researchers? *American Psychologist, Vol. 44, No. 4, pp. 717-724.*

Strupp, H.H. & Hadley, S.W. (1979) Specific versus non-specific factors in psychotherapy. *Archives of General Psychiatry, 36, pp. 1125-1136.*

Talbot, M. (1996) *The Holographic Universe*. New York: Harper Collins.

van Deurzen-Smith, E. (1996) The future of psychotherapy in Europe. *International Journal of Psychotherapy, Vol. 1, No. 1, pp. 15-21.*

Van-Deurzen, E. & Smith, D. (1996) Is Psychotherapy an Autonomous Scientific Discipline? A preliminary investigation. (trans) In Pritz, A. (ed) *Psychotherapie: eine neue Wissenschaft von Menschen*. Berlin: Springer.

von Ward, P. (2000) Subtle energy in human senses and powers. *Cosmic*

Light: Proceedings of the Remote Viewing Conference – Oasis Resort, Mesquite, Nevada.

Weyl, H. (1949) *Philosophy of mathematics and natural science*. Princeton, N: Princeton University Press.

Wilkinson, H. (1999) Pluralism as a scientific method in psychotherapy. *International Journal of Psychotherapy, Vol. 4, No. 3, pp. 313-328.*

Young, C. (2011). The Science of Body Psychotherapy Today: Part 4: New Science & Research. *USABP Journal, Vol. 10, No. 1, pp. 5-14.*