Mainstreams, Modalities and Methods in Psychotherapy: What criteria should be used in defining these?

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Definitions

What differentiates a psychotherapeutic 'method' or 'technique', from a proper 'modality' of psychotherapy, or a 'mainstream' within the 'field' of psychotherapy.

Psychotherapy is either: (a) the activity of the application of psychological theories into the clinical practice of psychotherapy i.e. as a form of 'treatment' for people in severe distress or with mental disorders, or the use of an intentional interpersonal relationship to aid someone with their problems of living; alternatively (b) psychotherapy (as a noun) is a cohesive combination of psychological theory and clinical practice into an establish and accepted way of working.

Whilst some European countries have legislated that psychotherapy (as in definition (a) above) is an activity that can or should only be done by psychologists or psychiatrists, most other countries (including the USA) accept that it is a multi-disciplinary activity, done by a variety of professional practitioners with a number of different qualifications, and that these include practitioners from professions like psychiatry, clinical psychology, counselling psychology, mental health counselling, clinical social work, marriage and family therapy, child and adolescent therapy, rehabilitation counselling, trauma counselling, music, art and dance-movement therapy, occupational therapy, psychiatric nursing, psychoanalysis, and several others.

Psychotherapy is now largely being seen, in Europe and in several other continents, as an emerging profession in its own right, and with legitimate links to several other professions, which include psychiatry and clinical psychology.

Psychotherapy, as a noun (definition (b) above), covers a wide and very varied range of psychotherapy approaches. Again, some European countries have legislated that only certain (often described as 'evidence-based') psychotherapies are acceptable (in that country) and these often include the three or four largely accepted 'mainstreams' of psychotherapy: psychoanalytic/psychodynamic, systemic, cognitive-behavioural, and some countries also accept some forms of humanistic psychotherapy.

However, there are many more broad types and these can be grouped into several 'main' 'streams' of psychotherapy and – depending on who does the grouping and their professional and political proclivities – these groupings can vary. Some of these 'mainstreams' have been mentioned already: psychodynamic; systemic; cognitive-behavioural; and humanistic psychotherapies – and each of these ‘mainstreams’ usually contains several ‘modalities’, ‘types’ or ‘methods’. For example: psychodynamic psychotherapy usually includes psychoanalysis, even though there are several different forms of psychoanalysis, and whilst psychodynamic psychotherapy is a form of depth psychology whose primary focus is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension, and whilst its roots are definitely from within psychoanalysis, psychodynamic psychotherapy tends to be briefer and less intensive than traditional psychoanalysis. So, many psychoanalysts would say that there is (or should be) a separate ‘mainstream’ of psychoanalytical psychotherapy, which would include Freudian, Jungian, Kleinian, Adlerian and Lacanian analysis – all with their different particular focuses within the main framework of psychoanalysis. Others would probably include psychoanalysis within the same mainstream as psychodynamic psychotherapy, perhaps for historical and quasi-political reasons, and so as not to make psychoanalysis too special.

Other often listed ‘mainstreams’ are body-oriented psychotherapies; existential psychotherapies; phenomenological psychotherapies; transpersonal and psycho-spiritual psychotherapies; integrative psychotherapies; expressive art psychotherapies (art, music, drama, and dance-movement), and multi-modal psychotherapies.

There are also different ways of working – these might be described as ‘specialties’ rather than ‘mainstreams’ – examples of these ‘specialties’ are as in ‘brief’ psychotherapy, or psychotherapy with different client groups, like working with children and adolescents. In psychology, forensic psychology is considered a different ‘specialty’, because of the different client group and the different training and knowledge requirements for working with criminals and prisoners; ditto educational psychology, a ‘specialty’ of working with the educational needs of children.

As regards other ‘mainstreams’, technically, to belong to a ‘mainstream’ group of psychotherapies, there should be some commonality of approach between the different methods or modalities within that mainstream, as in the various ‘body-oriented’ psychotherapies, or with the different expressive art psychotherapies. As in the psychoanalytic-psychodynamic example above, there should be a reasonably identifiable list of distinct psychotherapies, rather like ‘sub-headings’, within that mainstream grouping, and such that all these quite distinctive and different psychotherapies could generally agree to be grouped together under that ‘mainstream’ label. It has to work both ways.

The ‘integrative’ psychotherapies are sometimes (incorrectly) linked with the humanistic psychotherapies, and often combine one or more ‘modalities’ or ‘methods’, and then develop something of a meta-model for that integrative psychotherapeutic approach. One example of an 'integrative' psychotherapy is a combination of body-oriented techniques with Gestalt psychotherapy[1]; a second example is where psychodynamic psychotherapy is combined with hypnotherapy[2]; another might be cognitive-analytic psychotherapy[3] which combines ideas from psychoanalytic object-relations theory and cognitive psychotherapy.

Another definition can be where the word 'integrative' in integrative psychotherapy can also refer to integrating the personality, and making it cohesive, and to the bringing together of the "affective, cognitive, behavioral, and physiological systems within a person"[4]. 'Integrative' suggests the different elements form a cohesive whole and this is usually taken as being quite different from 'eclectic' where the elements are drawn more *ad hoc* from several approaches. Since there are various ways of integrating psychotherapies, there is probably a sufficient number of 'sub-headings' to include this as a separate mainstream.

Psychotherapeutic Methods or 'Modalities'

As we started off with two definitions of "psychotherapy", one of these, a particular type of psychotherapy (as in definition (b)) can be called a 'method' or a 'modality' to differentiate it from the larger 'mainstream' grouping of psychotherapies. There are literally hundreds of psychotherapeutic methods, modalities, approaches or schools of thought. By 1980, there were thought to be more than 250 (Henrick, 1980); by 1996 there were thought to be more than 450 (Maclennan, 1996). There are almost certainly more today, as the development of new and hybrid approaches continues across the world with a wide variety of theoretical backgrounds.

In order to be considered as a 'proper' modality within psychotherapy, there needs to be some sort of consensus about what that means: I am trying to get away from including just one or two people, with some technical and verbal skills, self-promoting their work as a 'proper' method or modality: unfortunately there are just too many of these. Whilst many or most modalities start out this way, and there is nothing wrong in that, there are those methods that do not stand the test of time, or may not be that effective over the long term with clients, or that cannot stand up to other colleagues' healthy critiques. Therefore, in order to be considered as a 'proper' modality within psychotherapy, one would prefer to see some or most of the boxes 'ticked' out of the following list: (a) a fairly comprehensive theory of human development; (b) a fairly comprehensive theory of the aetiology of a person's psychological problems; (c) an approach – based on that theory – towards the person needing help, from which a methodology has developed ("because we see your problems in this way, we do this and that"); (d) evidence that this approach and methodology is reasonably effective (hopefully not *just* from self-selected case histories and client accounts); (e) some indications and contraindications of whom or what the method is good for, and what sort of problems it is not good for; (f) a sense of connectedness as to where this 'modality' sits within the field of psychotherapy (perhaps what mainstream(s) it relates to) or what roots in which other psychotherapies does it have; (g) that there exist a number of published articles, preferably in peer-reviewed journals, and (h) maybe even a published book (preferably not self-published) and (i) that there has been some public presentation of these ideas or methods (at psychotherapy conferences, etc.); ideally, (j) inclusion in a meta-study or an anthology of psychotherapies by someone not connected with the method – peer-recognition; (k) almost certainly there have to exist a number of practitioners who have been trained in this method and are continuing to use it – out in the field of clinical practice; (l) a historical development of probably at least 5-10 years; and so forth.

Some methods and modalities try to resist an eclectic or integrative way of working and attempt to keep 'their' practitioners, those who trained in that method, continuing to work only according to that method. This can be seen in two ways: either as an attempt to keep the approach 'pure', and/or as a form of protectionism or control. Happily most modalities are open to growth and development of the original concepts, though – where one (often inspired) person has developed 'their' own particular method – one tends to find a little more rigidity.

Many practitioners – whilst they may have trained in one particular method – subsequently use a combination of several approaches (or techniques) in their work, so that they can alter their basic approach slightly at any time, based on their perception of the client's expressed needs. It is rare that one particular approach is ideal for every sort of problem, and thus practicing psychotherapists often 'adopt' other disciplines than the one they originally trained in. So this makes nonsense of any strict division or classification of practicing psychotherapists into their different and distinct modalities.

It is further clear from many meta-studies (viz: Seligman, 1995; Bergin & Garfield, 1994; etc.) into both the effectiveness and the efficacy of different methods and modalities that no one method or modality has been shown to be any more effective or efficacious than any other method or modality. Nor is it clear – despite many claims from within the various different modalities – that any particular modality is better than any other for treating a particular type of problem. It is highly probable that the most effective practitioner is the one who has been practicing the longest – irrespective of their training, degrees, accreditation, etc and irrespective of their theoretical orientation (Beutler et al: 1994). The 'common factors theory' asserts that it is almost certainly the factors that are common to most psychotherapies that makes psychotherapy reasonably successful – and that is: (i) the quality of the therapeutic relationship, and (ii) the commitment of the patient or client to the psychotherapy. Effectiveness studies, usually conducted through outcomes research, also have difficulty in distinguishing between the success or failure of the different approaches in psychotherapy, as those who stay in therapy longer tend to give a positive report to the 'long-term' relationship.

In *The Great Psychotherapy Debate* (Wampold, 2001) it was reported that: (1) psychotherapy is indeed effective; (2) the type of treatment is *not* a factor; (3) the theoretical bases of the techniques used, and the strictness of adherence to those techniques, are *not* significant factors; (4) the therapist's strength of belief in the efficacy of the technique *is* a factor; (5) the personality of the therapist is a *significant* factor; and (6) the alliance between the patient(s) and the therapist (meaning affectionate and trusting feelings toward the therapist, motivation and collaboration of the client, and empathic response of the therapist) is a *key* factor. This puts the nail in the coffin of any attempts to compare one method or modality against another: the differentiation is therefore totally descriptive and purely academic, with respect to any real distinguishing factors: *"Would you like the blue treatment, or the green treatment?"*

These research findings are largely supported by further recent research (Duncan et al., 2009) with the added point that systemic client feedback is necessary and important to improve effectiveness and efficiency. This book also moves the psychotherapy debate a few steps further away from the predominant 'medical model' (especially in America), and undermines the 'Dodo Bird' presumption that all therapies are equally effective.

Whilst much emphasis has been put – especially by the national health services and the insurance companies on using only 'evidence-based' methods – as a stated form of protection for the patients / clients (and for themselves) in an attempt to reassure people that no-one is using anything too radical, or untested – this 'safeguard' has several quite serious 'downsides' as well. Most of the 'testing' has been through randomized controlled trials (RCT) on people with single diagnosis conditions: i.e. only depression, or only anxiety, and not both anxiety and depression (which is much more common). The use of RCTs for psychotherapy is very contentious as the comparison is usually with people on medication, and with people having psychotherapy, and people getting both, compared with the control of people not being treated. Actually, it has been shown that psychotherapy and medication together is (perhaps not that surprisingly) the most effective. However, even these RCTs, tend to show that the therapeutic alliance is a hugely significant factor (Krupnick et al., 1996) and the most astonishing effects come from focusing on the importance of the client effect, *"the most parsimonious explanation for the dodo bird verdict is that it is the client, not the therapist or technique, that makes therapy work"* (Tallman & Bohart, 1999, p. 91)

One last point about methods and modalities: whilst it is generally accepted that there are at least 4 mainstreams: psychodynamic, systemic, cognitive behavioural, and humanistic – any of the other modalities and many of the sub-modalities within these mainstreams (eg: Lacanian within psychoanalytic, or Gestalt within humanistic) will probably – and this is important – have to go down the route of 'proving' the efficacy of their method by two or three studies in different countries using RCTs on single diagnosis patients and applying the usually accepted, 'governmental' conditions to this research. It is going to take the dinosaurs in the various health ministries many years to come to the realization that these methods of measurement are not at all appropriate, nor are they very effective. Therefore, in order to 'stay in the game' and 'create a reasonably level playing field' in the interim, all these different methods and modalities will just have to buckle down and 'do' this type of research. At the same time, they should also start to develop research parameters that are much more meaningful and relevant to psychotherapy.

The Science of Psychotherapy

It is increasingly clear that the biomedical definition of 'science' with randomized controlled trials and 'control groups' for single causal problems is **not** the appropriate form of science for psychotherapy, however much the governments and health companies try to insist upon this particular type of evidence-base. Much has been written about this, as there has been a great pressure since the 1950s to evaluate the clinical effectiveness of different psychotherapies. But what sort of 'science' really is appropriate? Governments and health insurance companies like numbers: this is quantitative. One type of 'science' that is increasingly popular is qualitative research:

> *However, psychotherapy research has been dominated by the methods of inquiry used within the disciplines of psychology and psychiatry, such as standardized measurement instruments (tests), diagnostic categories and experimental designs. It has not been easy for qualitative researchers to break down the resistance that many in the psychotherapy research establishment feel in relation to methods which appear (to them) to lack rigour and generalisability.* (McLeod, 2001, p. 1)

This type of research is also very different from "scientific validation". Firstly, as mentioned, there is the very contentious point about what type of 'science' is appropriate for psychotherapy and whether that determines whether a 'psychotherapy' can be practiced or not. Secondly, within psychotherapy, there is a political and practical problem. How do we discriminate between a 'scientific' psychotherapy, and a 'non-scientific' psychotherapy – a belief system, or a sect? And what is a psychotherapeutic method vs. a modality within psychotherapy? What are our appropriate criteria for acceptance?

The Scientific Validation process of accepting a Psychotherapy

Within the European Association of Psychotherapy (EAP), we are not scientists, we are mostly clinicians – with considerable levels of international experience. We have therefore 'used' science and have developed a 'list' of 15 different questions about scientific validation. These questions are based on scientific research parameters for other aspects of the social sciences and therefore they are reasonably applicable to psychotherapy. Anyone representing a branch of (what they call) psychotherapy, must go through a particular, fairly extensive process of acceptance, before the other 'psychotherapies' recognize them. This is a fairly common process of acceptance in any profession: *Who are you? What have you done and what do you do? Now, let's see how you measure up to our standards.*

A 'proper' modality of psychotherapy, that wishes to be recognized as a European-Wide Organization (EWO) representing that particular modality within the EAP, would have to fulfill a number of criteria: firstly, it has to have a legal status in one country; representation in 6 other countries; it has to accept the Strasbourg Declaration and the rules of the EAP; we have to accept that its constitution is democratic; it has to pay an initial fee and become a 'member' or an 'Ordinary Organization' within EAP, and so forth: but these are all initial 'membership' or 'political' criteria.

They would then have to come to meetings of the European Wide Associations Committee (EWOC) and eventually decide to become accepted as an EWO or EWAO. In order to do this, they have to present their 'Answers' to, or submissions about, the '15 Questions' on Scientific Validity, which are then peer-reviewed in some depth and detail, with written and circulated comments presented to the committee, prior to any acceptance. Whilst this is again largely a form of peer acceptance, the scope of the 15 Questions covers a lot of varied ground about the 'science' of the modality, and asks for various forms of empirical evidence. It requires the modality to demonstrate how they fulfill the criteria of the '15 Questions'. This provides a different sort of 'evidence-base' and we should not negate this as another form of 'evidence' or 'science'. The process of doing all this, and being so accepted, is actually quite discriminating as well as affirming.

Next comes the process of aligning the modality's training to the EAP model, as set out in the European Certificate of Psychotherapy (ECP) document.[5] This clearly establishes psychotherapy training clearly at Master's degree level, with entry into the training being at post-graduate level, (after a relevant Bachelors degree) extending for a 4-year minimum of about 1300 hours of training, comprising of a broad theory training, an extensive amount of supervised practice, knowledge of psychopathology and experience in a psychiatric or clinic setting. This level of professional training is completely in line with the European Union CEPLIS[6] definition of a 'liberal profession' with a minimum of 7 years tertiary education and practical training – akin to that of architects, engineers, human management, etc.

Methods or techniques that are developed within psychotherapy usually do not expand to become a 'proper' modality. The Autogenic Therapy technique, originally developed to reduce hypertension, has been expanded in a few countries (like Austria) to be recognized as Autogenic Psychotherapy, a modality within psychotherapy; EMDR, despite the extravagant claims made for it, is still a technique that is used only by some psychotherapists of different modalities; Mindfulness practice is similarly an increasingly recognized effective technique, especially within CBT, for the treatment of anxious depression and pain management, despite being a 2,500 year old Buddhist practice.

This is something of what we mean by a "psychotherapy" and by "a modality" within psychotherapy. We believe that we are open to pioneers and new innovations in psychotherapy, as long as they are genuinely working to meet these levels of criteria, but we are also able to avoid accepting sects or belief systems, disguising themselves as, or calling themselves, a 'psychotherapy'. We have rejected several so-called 'modalities' on a variety of grounds.

In requiring all this within the EAP, and we have accepted about 30 different modalities by this method, we also recognize that there are several very 'proper' modalities within psychotherapy that would fit all – and more – of the previously mentioned criteria, that have chosen not to be members of the EAP – yet – for their own very valid political reasons. We are therefore – most emphatically ***not*** claiming that the 'scientifically validated' modalities within EAP are the only 'proper' modalities. Requiring all this fulfillment of various criteria, does give us a particular tried and tested 'yardstick' with which to 'measure' other modalities – and we should be clear that we have rejected several modalities as not meeting the requirements of the 15 Questions sufficiently. However, there is another set of criteria that must be mentioned.

Professional Competencies

The European Union decided to use – as a form of measurement – the concept of professional or functional competencies. What is a member of a trade or profession expected to be able to do? And has this person demonstrated their competency in that trade or profession. The significant document about this is a report available from CEPLIS, *Skills and competencies for mobility in a competitive Europe* (Tratsaert & De Smedt, 2009). This lays down the developments of the 1951

Treaty of Paris and the 1957 Treaty of Rome, that established the European Economic Community (EEC) or 'Common Market' (as it was then) on the basis of the free movement of labour across Europe. This is still the *raison d'être* of the European Union.

I have written about this theme of establishing the professional competencies in psychotherapy elsewhere (Young, 2008) but the point I want to make here is that the establishment of these professional competencies requires each modality to: (a) agree to the "Core Competencies" – which are common to all psychotherapies; and (b) differentiate the "Specific Competencies" that are unique to that modality. This will become the Occam's Razor[7] that will define the different mainstreams and modalities, as, if several different modalities share some competencies, then they may be able to co-exist within a particular mainstream, and, if two different modalities share the same competencies, then, to all intents and purposes, they are the same – despite whatever they call themselves. We will, at last, have a definitive set of criteria by which to assess these differences between mainstreams, modalities and methods.

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Endnotes

1 Body-oriented therapy & Gestalt: viz: (i) Rubenfeld Synergy, combining Alexander Technique, Feldenkrais and Gestalt; or (ii) Psychotherapeutic Postural Integration, combining Postural Integration & Gestalt.

2 Psychodynamic and Hypnotherapy: viz: Kraft, T. & Kraft, D. (2007). Irritable Bowel Syndrome: Symptomatic Treatment Approaches versus Integrative Psychotherapy. *Contemporary Hypnosis, 24, (4): pp. 161-177.*

3 Cognitive-Analytic Psychotherapy: Ryle, A. (2005). Cognitive analytic therapy. In J. C. Norcross & M. R. Goldfried (Eds.), Handbook of psychotherapy integration (2nd ed., pp. 196-217). New York: Oxford.

4 Staff. "The Association: Definition of 'Integrative' in Integrative Psychotherapy". *International Integrative Psychotherapy Association*: http://www.integrativeassociation.com/the_Association.html. Retrieved 2009-06-05.

5 ECP Document: available on the EAP website: www.europsyche.org

6 CEPLIS: European Council of the Liberal Professions: CEPLIS is the only inter-professional association representing the liberal professions at Community level. As such, it is an organization approved by the European Economic and Social Committee (EESC). The aim of CEPLIS is the study and promotion, both at the scientific and cultural level, of information and data related to the exercise and policies of the liberal professions. www.ceplis.org/en/index.php

7 Occam's Razor: Is a phrase referring to a meta-theoretical principle that "entities must not be multiplied beyond necessity" and the conclusion that the simplest solution is usually the correct one. The principle is often expressed in Latin as the *lex parsimoniae* (translating to the law of parsimony, law of economy or law of succinctness).