Validity in the psychological therapies: why love provides a better benchmark than science

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> Where love rules, there is no will to power, and where power predominates, love is lacking. The one is the shadow of the other.
> Carl Jung, *Modern Man in Search of a Soul*

In recent years I have come to see my work with, and around clients as research. My inquiry topics are love and the antithesis of love, the cultures of domination that stall or diminish love. My research methods are Action Research and Cooperative inquiry. For several decades I have pursued inquiries into behaviour and beliefs in the psychological therapies in the UK, for example my recent book 'Regulating the Psychological Therapies'.

A recent outcome of this research has been the realisation that the process of implementing state regulation in the psychological therapies is revealing a gross distortion in what counts as validity in working with the human condition. A model of validity for the psychological therapies based on a narrow scientific approach to research is being embraced by the Department of Health, who appear to be convinced that this is the only option. They are mistaken. The Department of Health and its advisers are suffering from myopia. They fail to notice that the hugely diverse range of psychological therapies themselves offer a competing paradigm of validity, one that more than matches the 'scientific' ethos the Department of Health prefers. These two paradigms of research can be distinguished by their approach to power.

Evidence-based practice, the 'scientific version,' derives from and mimics evidence-based medicine:

> validity derives from:
>
> research *on* people
>
> research is institutionally focused and institutionally funded, expert-led and controlled and interpreted,

research methods are autocratic, hierarchical, and 'power over' in style

outcome validities: questions about efficacy and cost effectiveness of treatment protocols are answered through data collection and statistical meta analysis of double-blind random controlled trials. A high value is given to answers to social questions such as, do people return to work? Has happiness increased?

Validity in this scientific approach to research leads to preferred treatment protocols being listed in the NICE 'mental health' treatment guidelines. For the full flavour of what this means visit the NICE website and look at: # CG22 Anxiety: Algorithm (management of generalized panic disorder in primary care)

In the psychological therapies, there is a parallel universe:

validity derives from:

inquiries *with* people.

These feature cooperative, therapeutic working alliances, 'power with', relationships that are negotiated, personal, local, and flexible

validity of outcomes reflects diversity of inquiries - there are at least 40K+ practitioners working with hundreds of different idioms of inquiry

outcomes and efficacy are negotiated and re-negotiated cooperatively between practitioner and client And even where the practitioner needs to hold his or her ground, and relations get a bit feisty, it remains negotiation.

That's to say, in most of the psychological therapies, validity is client defined. Isn't that how it should be?

The purpose of this article is to argue that the second of these, the diverse range of psychological therapies, is a highly valid form of research. And that it is also the appropriate approach for inquiring into, and for working with, the human condition.

The notion of power as an intrinsic underlying issue in all research may be an unfamiliar one, so let us back off, and look in turn, at each of these research paradigms and the cultures that shape them.

First a brief taste of the culture of psychological therapies that base themselves on evidence from co-called 'scientific' research.

> For Trials 1-8 the main interview-based outcome measures were: Anxiety Disorders Interview Schedule - DSM IV for diagnosis and comorbidity, Clinical Global Severity (0-8), and the Hamilton Anxiety Rating Scale….
>
> (Durham, 2006)

The UK Department of Health embraces and endorses a culture of statistics, measurement, scales, and DSM IV style 'disorders', and the belief that accompanies it about what constitutes valid psychological

knowledge about the human condition. They appear to believe that an evidence-base deriving random controlled, double-blind trials coupled with meta-analysis of groups of trials provides a gold standard for validity. And they only endorse, which means pay for, the commissioning of psychological therapies that mirror this belief about validity.

The problem with this is that it *is* a belief. Holding that validity in the psychological therapies is exclusive to very specific scientific forms of research, is an ideology. It's driven by an unexamined set of beliefs that displays ignorance of or denial about, the role of power in defining validity. And at the heart of these beliefs, I want to argue, is the unconsciously held notion that for the Department of Health power means 'power over' – that domination and compliance are natural and inevitable.

What does 'power over' mean in psychological research? It means that researchers decide what to research, which tends to mean that they study what will get funded; they decide the research methods, they seek out 'populations' to study, and go to elaborate lengths to distance themselves from the people being researched.

I know that there are 'listening exercises', 'consultations' and 'user groups', but this further example, from a study of the efficacy of CBT, demonstrates the distancing I'm talking about.

> The main patient-rated measures were: Brief Symptom Inventory, SF-36 II, Clinical Global Improvement (1-7), Positive and Negative Affect Scale and the trait version of the State-Trait Anxiety Inventory. For Trials 9-10 the primary outcome measure was the interview-based Positive and Negative Syndrome Scale (PANSS).
>
> (Durham, 2006)

The result, as far as the psychological therapies such as CBT are concerned, is the development of 'healthcare' treatment protocols that mimic medical procedures. Client problems are diagnosed within a 'mental health' framework. Expert diagnosis is applied, treatment is prescribed, and the role of patients is to be compliant and defer to what is on offer. The version of research validity that the Department of Health subscribes to derives from, and reflects, this autocratic take on power.

From the perspective of the non-coercive culture of practitioner/client alliances, it is important not to forget that the Department of Health is an Office of the State, and that behind their facades of consultation, coercion and enforcement is their trade, it's what they are hired to do. If we were in doubt about how close we are to the state, take a penny out of your pocket and look at the back of it: the State icon, the crowned portcullis, says it very clearly.

The state represents itself as the barred entrance to a fortress with free-floating chains that end in manacles, plus the ultimate icons of top down power, the crown topped by a cross. This is the State that has been invited to regulate and control the psychological therapies. Perhaps we shouldn't be surprised to find it enacting an imperious approach to power – map, measure, capture, and as I have elsewhere argued, stuff.

In the Department of Health's fiefdom, the NHS, in medicine, and in 'mental health', power continues to be expressed vertically, as 'power over', autocratic, male-dominant decision-making. At the top…

Professor Louis Appleby, a key advocate of evidence based practice in the psychological therapies who was… until very recently… 'National Mental Health Czar', (his email address is: mental-health-czar@doh.gsi.gov.uk) And the engine of these coercive ideologies is fueled by fear. This is especially the case with Department of Health policy and practice. Clients *must* fear malpractice, practitioners *must* fear mistakes. The government *must* fear another Shipman.

Must, must, must. The Health Professions Council publishes a booklet 'Standards of Conduct, performance and ethics. Your duties as a registrant', that uses the word 'must' 84 times in eight pages. The Department of Health's preferred scientific psychological research methods are similarly coercive and autocratic. Through 'double-blind, randomized, trials', researchers must be in total control of all variables, and 'alienated' from the people they study due to a secondary belief that bias, i.e. subjectivities such as projection, introjection, denial, displacement etc. can and must be eliminated.

I collected a list of subjectivities from which the research has to be cleansed.

Attrition bias
Berkson bias
Confounding bias
Centripetal bias
Diagnostic access bias
Diagnostic purity bias
Diagnostic suspicion bias
Diagnostic vogue bias
Exposure suspicion bias
Family information bias
Interviewer bias
Membership bias
Misclassification bias
Missing clinical data bias
Non blind diagnosis bias
Non blind test interpretation bias
Non-respondent bias
Partial verification bias
Performance bias
Prevalence-incidence bias
Recall bias
Referral filter bias
Selection bias
Unmasking bias

Only, it is claimed, if all of these subjectivities are eliminated from the research methodology, can 'objective knowledge' be extracted from the results about what counts as 'normal', and how to correct what is held to be 'abnormal' in the human condition.

This is deeply problematic. It is problematic because this is research *on* people, it is violent, and it reduces people to

inanimate objects. And it's problematic because double-blind randomized trials mean that the research is also blind to being, to subjectivity, to emotionality. It only recognises in the human condition what can be externally measured.

And it's problematic because its focus on what is universal and repeatable encourages us to think that the uncertainties and unpredictability of the human condition can somehow be conquered and controlled. And 'scientific' psychological research of the kind the Department of Health endorses, promotes the modern myth that everything that matters about us as persons can be known, but only if there is more, preferably better funded, research. Isn't it more likely that because we are embodied beings, everything that matters about the human condition is *unknown*, and some fragments of it can be uncovered?

This not to be disparaging of science. In a previous life, so to speak, I made numerous films about science and the sociology of science, including three about high energy physics, and my book about high energy physics, Fabric of the Universe, was translated into several languages. The physical sciences are one of the great human achievements. However…

Applying the scientific research methods of the physical and biomedical sciences to generate validity in psychological matters, as the Department of Health does, misuses them, and as we can see with CBT, it concentrates way too much esteem in too few hands. For example, the Department of Health's preference for 'evidence based, ie 'scientific' 'evidence based practice' is presently on the way to delivering a grotesque distortion in the choices available to clients. Only evidence-based psychological therapies, those carrying 'scientific validity', which means CBT, will be available through the IAPT, Increasing Access to Psychological Therapies, programme.

It is as though we were being advised that scientifically, only hamburgers had validity as food. This denies the whole huge universe of nourishment for client needs that the rest of the psychological therapies embody.

Let us now turn to them. Here is a reminder of the diversity and range of what is presently available.

Acceptance and Commitment Therapy (ACT)

Adlerian therapy

Analytical psychology

Art Therapy

Attack therapy

Attachment Therapy

Attachment-based psychotherapy

Autogenic training

Behavior modification

Behavior therapy

Biodynamic psychotherapy

Bioenergetic analysis

Biofeedback

Bionomic psychotherapy

Body Mind Psychotherapy

Body psychotherapy

Brief therapy

Classical Adlerian Psychotherapy

Characteranalytic vegetotherapy

Child psychotherapy

Child therapy

Client-centered psychotherapy/counselling

Co-Counselling

Cognitive Behavior Therapy (CBT)

Coherence therapy

Collaborative therapy (Collaborative Language Systems)

Concentrative movement therapy

Contemplative Psychotherapy

Core Energetics

Core process psychotherapy

Dance therapy

Depth Psychology

Dialectical Behavior Therapy (DBT)

Dreamwork

Drama therapy

Dyadic Developmental Psychotherapy (DDP)

Ecological Counseling

Emotional Freedom Techniques (EFT)

Encounter groups

Eye Movement Desensitisation and Reprocessing (EMDR)

Experiential Dynamic Psychotherapy

Existential therapy

Exposure and response prevention

Expressive therapy

Family Constellations

Family therapy

Feminist therapy

Functional Analytic Psychotherapy (FAP)

Focusing

Freudian psychotherapy

Gestalt therapy

Gestalt Theoretical Psychotherapy

Group Analysis

Group therapy

Hakomi

Holistic psychotherapy

Holotropic Breathwork

Holding therapy

Humanistic psychology

uman givens psychotherapy

Hypnotherapy

IBP Integrative Body Psychotherapy

Integral psychotherapy

Integrative Psychotherapy

Intensive short-term dynamic psychotherapy

Internal Family Systems Model

Interpersonal psychoanalysis

Interpersonal psychotherapy

Jungian psychotherapy

Logotherapy

Marriage counseling

Milieu Therapy

Mindfulness-based Cognitive Therapy

Mindfulness-Based Stress Reduction (MBSR)

Method of Levels (MOL)

Morita Therapy

Multimodal Therapy

Multitheoretical Psychotherapy

Music therapy

Narrative Therapy

Neuro-linguistic programming (NLP)

Nonviolent Communication

Object Relations Psychotherapy

Orgonomy

Parent-Child Interaction Therapy (PCIT)

Pastoral counseling/therapy

Person-centered (or Client-Centered or Rogerian) psychotherapy

Personal construct psychology (PCP)

Play therapy

Positive psychology

Positive psychotherapy

Postural Integration

Primal therapy

Primal integration

Process Oriented Psychology

Provocative Therapy

Psychedelic psychotherapy

Psychoanalytic psychotherapy

Psychoanalysis

Psychodrama

Psychodynamic psychotherapy

Psychological astrology[POV]

Psychosynthesis

Psychosystems Analysis

Pulsing (bodywork)

Radix therapy

Rational Emotive Behavior Therapy (REBT)

Rational Living Therapy (RLT)

Rebirthing-Breathwork

Recovered Memory Therapy

Re-evaluation Counseling

Reiki

Relationship counseling

Relational-Cultural Therapy

Relational Empowerment Therapy

Reprogramming

Reality therapy

Rubenfeld Synergy

Reichian psychotherapy

Rolfing

Self-relations Psychotherapy (or Sponsorship)

Sensorimotor Psychotherapy

SHEN Therapy

Social Therapy

Solution focused brief therapy

Somatic Psychology

Sophia analysis

Systematic desensitization

Systematic Treatment Selection (STS)

Systemic Constellations

Systemic Therapy

T Groups

Thought Field Therapy

Transactional Analysis (TA)

Transactional Psychotherapy (TP)

Transpersonal psychology

Twelve-step programs

Unitive Psychotherapy

Vegetotherapy

A rich mix, you might think, more than a hundred and thirty different therapies and therapeutic approaches, each offering one or another kind of inquiry into the human condition.

What does a practitioner like me from one of these psychological approaches, the humanistic psychology tradition, have to say about working with the human condition? What are the priorities?

The human condition is a rich and fertile landscape. We make choices, and often let them pass by. We understand a little, and misunderstand a lot. We seek out love and yet often reject or deny it. The human condition unfolds through an infinite variety of lives, with myriad different styles of formation, of genetic background, of upbringing - and all of it held in our bodyminds.

What scientific research works hard to eliminate, and the psychological therapies generally exist to honour, are bodies, and bodyminds. The sensitive knowing of skin… The inner rhythms of heart and breath… And especially the inner subjectivities that inhabit us.

Suppose I was to let you into my bodymind for a moment, what might you find? Hmm… There's a lot going on… Memories… Thoughts…Feelings.

The embodied qualities of the human condition such as these, demand an approach to validity that honours the organic, embodied unfolding of its infinite varieties of subtlety, subjectivity and emotionality, of both distress and delight.

Can we widen how we frame the psychological therapies from 'helping' and 'caring' to see them as 'research'?

The psychological therapies:

- honour embodiment as a container for our history and

as the wellspring for feelings, emotionality, intuition, thoughts and action.

- see development, learning and emergence as higher priorities than 'health'

- respect the autonomy of persons as able (or potentially able) to negotiate self-care and self-help for themselves.

- honour the diversity of the human condition via multiple models of human functioning that are not limited to medical concepts of 'mental health'

- are congruent with modern theories of meaning, that point to meaning being co-constructed rather than given.

- carry an awareness of group dynamics, especially that much intrapersonal, interpersonal and social distress derives from the unconscious embedding of the notion that dominance and subordination are natural and inevitable.

- outcomes are client defined and client validated.

This amounts to a valid form of research into the human condition. Making these ingredients available in a therapeutic alliance needs a practical, close at hand, mode of delivery. There is a working method that matches them and that provides a framing for validity: it's something I'd guess that as a practitioner you already deliver. Let's call it love.

Love, you say? What's love got to do with it? For me, love is a name for the active promotion of human flourishing through cooperative engagement—and strategies rooted in 'power with' relations with others—that seek to evoke 'power from within'.

Yes, flourishing may seem out of reach for clients who are filled with a need for support, for daily survival and recovery from harm, but I tend to believe that flourishing is as relevant an agenda, an option, for persons, as it is for the amaryllis next to where I am writing, that has produced eight huge flowers in recent weeks.

And if love is the ground we stand on as practitioners, we are holding a space for flourishing to enter. Love sings, love cherishes. Love can confront and set boundaries. Love can hold complexity and ambiguity and honour the unknown. Isn't this what you bring to your client work? If you are a client, isn't that what you seek from a practitioner?

Ok, so this is my take on work with the human condition, but the core practice of almost all the psychological therapies can be seen as 'love in action' and it points to a form of validity in client outcomes that stands comparison with any other approach to validity that is on offer. And yet astonishingly, this non-coercive, cooperative approach to validity in the psychological therapies is greatly under-valued and in danger of being comprehensively marginalized by the rush to sign up to what the Department of Health has decided is good for us.

Happily there are a few user-friendly things that we can do to confront this.

- We can re-affirm our personal commitment to a non-coercive style of work with clients based on our own version of 'love in action'.
- We can start seeing all the work we do with clients as having a research dimension; we can see it and describe it, as 'Cooperative Inquiry', the outcomes of which are client defined, and client validated. And which constitute a valid form of research.
- This is not to replace one orthodoxy with another, but to deepen the value of the work we already do by realizing it already sits in an established, ethically sound research framework, Action Research, that matches our non-coercive ethos, and which, historically, has grown out of the psychological therapies.
- We can publicly affirm that we require any form of civic accountability we sign up to, to be as free of force and coercion as we are in our work with clients.
- Finally, we can try to persuade the Department of Health to value the multiple outcomes of these inquiries, which clients specify and which they also verify, as the primary source of validity that grounds psychological work in the UK.

I did the arithmetic. Across the psychological therapies field, this amounts to at least twenty million contact hours a year of intrinsically valid research *with* people. How can this have been ignored or denied for so long?

Coda

The incompatibility between these two approaches to validity is huge. You might think that an intelligent government would honour the validity of the 'power with' ways of working that are rooted in love. They might even have applied to themselves, the longstanding ethical critiques of the abuse of power that these therapies have developed. But the Department of Health remains committed to the intrinsic righteousness of their technocratic approach to validity.

The Regulator, the Health Professions Council, a managerial panopticon of audit, surveillance and fear, has all the legal instruments of coercion—sanctions, auditing, control of trainings and the criminalizing of dissent—which they need to *enforce* compliance with the state's preferred form of 'scientific' validity for the psychological therapies.

Happily as of Spring 2008 the mainstream psychological therapies appear to be waking up to the incompatibilities between these two competing paradigms of validity. Following the dismissal of the Integrative Humanistic modalities by the Prime Minister in a petition response, the UKCP wrote to its Member Organisations asking them to prompt registrants to contact their MP with objections to this exclusion.

For the moment, however the present disputes about validity play out, if you are a practitioner, you can expect to feel coerced, anxious, and ethically compromised. If you are a client, expect to pay for the administration of all of it.

Let's wish ourselves good luck. We'll need it.

For a video version of this article see http://ipnosis.postle.net/psycholodeon.htm

Further reading

Critical Appraisal - read clinical papers with confidence: http://www.criticalappraisal.com/

Durham, R., (2006) Long-term outcome of cognitive behaviour therapy (CBT) clinical trials in central Scotland 7 June 2006 Research Findings Register: summary number 1569 http://www.iapt-cbt.info/DurhamReFeR.pdf

Heron, J., (1996) Cooperative Inquiry: Research into the Human Condition Sage

Living From Love http://www.livingfromlove.org

NICE Guideline # CG22 Anxiety: Algorithm (management of generalized panic disorder in primary care) http://www.nice.org.uk/nicemedia/pdf/CG22AlgorithmGenAnxietyDisorder.pdf

Postle, D., (2007) What counts as Evidence? From survival and recovery to flourishing – a residential cooperative inquiry May 7 1998 in Postle, D., Regulating the Psychological Therapies PCCS Books Chapter 26

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Postle, D., (1978) Fabric of the Universe Macmillan

Reason, P., Bradbury, H., Eds., (2007) Handbook of Action Research Sage

Wickipaedia: http://en.wikipedia.org/wiki/List_of_psychotherapies
See also: http://en.wikipedia.org/wiki/List_of_therapies

Denis Postle is a writer, artist and musician who has had a counselling, facilitation, supervision and psychotherapy practice for 23 years. He made over forty films for television and published three books on science and psychology topics, plus a CD introduction to Humanistic Psychology, 'Letting The Heart Sing: The Mind Gymnasium'.