Psychotherapy and Questions concerning Its Regulation

This brief is a response to the current discussion as to whether psychotherapy should be a controlled act and whether psychotherapists should be regulated as a profession under the Registered Health Professions Act.

I. Introduction

The effort to arrive at appropriate regulation models for psychotherapy must proceed from a clear understanding of what psychotherapy is and how it is being practiced in Ontario at the present time.

Considerable time has to be taken to get psychotherapy "into one's sights." People working in the field itself must be heard from.
The rewards for such efforts are rich: the discourse becomes correspondingly more grounded, vital, and accurate.

Moreover, in the process, approaches to regulation emerge more clearly.
That is to say, certain practical implications that follow from examining psychotherapy practice stand forward clearly. Creative and more customized regulatory modes suggest themselves. (These will be indicated in box format below).
On a more negative note, the discussion of whether and how psychotherapy ought to be regulated is often crippled by misconception and cliché. If interventions in this matter were to be based on flawed information, the consequences would be harmful to the whole field and to the public it serves.

II. What Psychotherapy Is

1. 'Psychotherapy' escapes ordinary attempts at definition.

Dictionary definitions of the term 'psychotherapy' typically:

*offer an explanation of its etymology, that is, the healing or care (from the Greek word *therapeia)* of the soul or mind or spirit (*psyche*, also Greek);

*note that it refers to disciplined methods for bringing this about;

*offer an often lengthy list of examples intended to convey how the term is used. These include psychoanalysis, play therapy, psychodrama, family and couples therapy,cognitive-behavioural modification, art and music and dance therapies, group therapy, transcendental meditation, etc. The lists can be very lengthy.

What is noteworthy here is that without the list of examples, the definition could apply to an almost endless number of other human activities (sports, education, etc.). The 'definition', then, can hardly be called *defining or essential*.
However, no defining or essential features can be added that wouldn't exclude some of its examples.

By contrast, dictionary entries for medicine (as a practice) or physiotherapy or law set forth the defining and essential features of each of these.

Here is an early signal of the basic difference between psychotherapy and many other professions:

'Psychotherapy' is a different kind of category, one that is characterized by 'family resemblance' rather than a common essence.

Linguistic philosopher Ludwig Wittengenstein gives as an example of this difference the category 'game'. One can always find similarities between games but no single definition that applies to all. Some games are played with balls, but not all; are competitive, are played in teams, etc, but not all. 'Psychotherapy' is what linguistic analysis describes as a grouping based on family resemblance.

The present discourse on the regulation of psychotherapy offers one of the few occasions when 'psychotherapy' as the whole family has come under observation.
Like all such large family gatherings, it becomes apparent to its members which among the relatives are close kin, which are familiar, and which are related only by marriage. Also apparent is where conversation tends to be lively or more strained.

The profession of psychotherapy is multidisciplinary and heterogeneous in its forms. It cannot therefore be placed under the aegis and regulation of any one discipline. Too many of its approaches inevitably fall outside the competency of any one discipline
Psychotherapy cannot even be defined as a health service, for sometimes it is and sometimes it is not.

2. The metaphor of family resemblance aptly applies in another way because these forms of psychotherapy derive from a common ancestry.
3.

Psychotherapy is a modern discipline that has evolved over the last century and a half from a number of traditions. The first of these were religious and spiritual traditions, then medicine, philosophy, psychology, education, social sciences, the humanities and the arts yet Psychotherapy is 'a new thing.'

Its founders were insistent that what was emerging was a new discipline.
Because the new forms of 'care for the soul' share so much common ground with these parent disciplines, it has been all too easy for those practitioners--doctors, pastors, educators and social workers--to presume that their original training also virtually trained them to practice psychotherapy.

This presumption is still acted upon.
However, there have been healthy developments in this regard. The disciplines of medicine and social work and pastoral care have all taken steps to insist that their members acquire training appropriate to the psychotherapy they begin to practice.

3. The cradle of modern psychotherapy practices was the psychoanalytic movement initiated by Sigmund Freud and several remarkable associates.

Among those who collaborated and were variously associated in the first quarter-century were Alfred Adler (Adlerian Psychology), Carl Jung (Analytical Psychology), Wilhelm Reich (Bioenergetics), Jacob Moreno (Psychodrama), Anna Freud, Melanie Klein (Child and Adolescent Therapies), Freida Fromm Reichmann (post-war trauma therapy), Margaret Mahler (Pediatrics and Child Analysis), Etc.

These approaches collectively originated what has come to be known as psychodynamic psychotherapy.

The innovative work of Freud, Adler and Jung respectively established the first schools of the new psychotherapy. They continue to be active in the present day. To make the point closer to home, each of them has training institutes in Toronto.

4. Characteristics of Psychodynamic Psychotherapy

A) The major psychodynamic therapies are characterized by clear self-definition.
This is ensured by a training that is defined and specific and by an emphasis on long term collegiality and professional development.

Since the training includes a major experiential component, its signature elements are offered in programs run by its practitioners.

Also characteristic of the major psychodynamic therapies is that they demand that their students enter the therapy for which they are training to practice.

In other words, the originating psychodynamic psychotherapies had and continue to have clear self-regulatory structures. They offer a different regulatory model and one tested by long usage.

The existence of these long established models of regulation cannot be dismissed. On the contrary, they appear as uniquely valuable assets in the work of ordering and improving psychotherapy practice

B) Psychodynamic therapy in its original form is the dyadic or one-to-one meeting between the practitioner and the patient/analysand/client.

It is an interchange designed to enhance and expand the self-awareness of the person in therapy: it works at attentiveness to a different register, namely to the continual, more hidden and ignored activities of one's consciousness, that are nevertheless continual and active as powerful influences on behaviour.

Subtle alterations of consciousness occur. In this respect it is commonly compared to the discipline of meditation, though it is meditation *a deux*

The basic dyadic form was also quickly expanded to include forms and modalities that differently alter and enlarge consciousness of oneself and oneself with others. Psychodynamic therapies include: working in groups and the use of modalities drawn from drama, movement, music and art.

5. The other major psychotherapy stream is cognitive-behavioural.

This therapeutic approach works directly with what is conscious to the client (cognitive) and what is empirically observable by the therapist (behavioral). It therefore makes claim to an objective body of knowledge and set of techniques.

This is a therapy that works at altering clearly identified cognitive-behavioural patterns. Before beginning treatment it also typically defines the parameters for the length of treatment. The behavioural stream, stemming from J.B Watson early in the 20th century, explicitly excluded the realms of consciousness and will from its sphere of relevance.

Historically, then, behaviourism needed to join with the exploration of cognition, in order, as it were, to get 'inside' the client.

Cognitive therapy's partial openness to what the psychodynamic therapies call 'psychic reality' has made possible some contemporary ecumenical meetings.
There is a great deal of promise for the future of psychotherapy in this openness.

Cognitive-behavioural therapy is taught for the most part within departments of academic psychology. Training for it is uniquely suited to the university ambience. It grounds itself in an objective body of knowledge and set of techniques. It does not require that its students personally undergo this therapy.

Cognitive-behavioural therapy offers a psychotherapy that is an attractive auxiliary to professionals in the health services. This is the case with medicine, psychology, education and social work, whose training also includes a substantial and extensive university component.
Its university ambience also makes it attractive as a ready and promising candidate for regulation.
The problem here is that this characteristic sets it apart from most other forms of psychotherapy.
Moreover, training for most psychodynamic modalities includes experiential, personal and evaluative components that a university setting is not designed to provide,

Therapies based on the cognitive-behavioural model are described as 'short-term' and 'direct.' These terms imply their contrast to psychodynamic psychotherapies, which focus on insight as processive or emergent, and correspondingly resist predicting length of treatment.

6. These two therapeutic modalities--psychodynamic and cognitive-behavioural--can probably be said to model most of psychotherapy practice at the present time**.**

Despite their obvious differences and tendency to mutual opposition, they both focus on the nature of human consciousness and choice. They recognize that consciousness (intelligence) and choice (will, freedom) are mutually interactive, in that: an increase in consciousness reveals new options; freedom (from preconception, anxiety, etc.) releases awareness

Therapeutic techniques in both approaches are designed to help people free themselves from internal constraints and develop in more integrated ways.

Because intelligence and freedom are the capacities engaged between subject and therapist alike, it could be said that psychodynamic and cognitive-behavioural therapies, when they are practiced autonomously (free of larger contexts), offer the most unequivocal examples of what psychotherapy does.

7. The on-the-scene practice of psychotherapy in Ontario today comprises such a heterogeneous spectrum of disciplines, adaptations and mixed models that a sense of it can only be conveyed by a series of examples.

It is the versatility of psychotherapy, its adaptability and quasi-ubiquity among the health services and beyond them that makes it unique among the disciplines.

This same versatility poses overwhelming difficulties to any attempt to make it a regulated and controlled act

Heterogeneity results from the convergence of differentiating principles at work.

A. There are distinguishing differences among those who enter psychotherapy:

i) Some of these are individuals with serious psychotic disorders who require medication and/or custodial care. Obviously their treatment is presided over by medical doctors. Treatment may also include a psychotherapy component, such as cognitive-behavioural therapy and/or (probably less often) psychodynamic therapy.

ii) There are groups of people who enter therapy because they are *required* to do so:
*Individuals indicted for family violence may be required to participate in psychotherapy in the form of support groups.

*Individuals suffering from addictions may similarly be required to undergo rehabilitation therapy.

*Juvenile offenders are also typically among these individuals entering psychotherapy by court injunction.

iii) People may enter psychotherapy programs offered within institutions and public agencies. Examples are family therapy, meetings with children in school settings, sessions with people under the care of social workers. Pastoral programs such as couples' counseling and retreats often include forms of psychotherapy.

iv) Many seek psychotherapy in order to enrich and broaden their professional performance.
A number of these also go on to train in psychotherapy.
This is a pattern, for example, among

*some clergy and lay ministers, who offer spiritual direction, or who act as chaplains in hospitals and prisons;

*many actors and dancers;

*physiotherapists and occupational therapists, massage therapists, yoga teachers;

*teachers.

v). A large population of people entering psychotherapy, however, seek out and pay for the psychotherapy of their choice.
Typically, they do not suffer from serious psychotic disturbances that leave them dysfunctional socially and economically.
They have in common a resolute search for a better quality of life: in respect to their relationships and work, and in their sense of the meaningfulness of their lives.
These individuals avail themselves of an array of psychotherapies but probably can be said to be most drawn to psychodynamic ones.

Attempts to regulate or control psychotherapy services sought by this (v) sector of the population in particular meet with almost insuperable obstacles, in that they encroach upon religious and civil liberties.

B. The social and professional context or domain in which psychotherapy is offered can radically affect its nature and qualities**.**

The most important differentiation occurs when individuals are *required* to engage in psychotherapy, as is the case in the groupings described above under i), ii) and sometimes iii) The condition affected most essentially is confidentiality, because evaluations of the effectiveness of the therapy must be made to a third party. That is, the therapy is accountable to external forum.

These evaluations/diagnoses occur most typically in medical and legal venues. They can exert the most radical modifications upon psychotherapy.

In these instances the psychotherapy is carried out by practitioners from regulated professions, such as medical doctors, social workers and psychologists. It is regulated by virtue of association.

C. Even among practitioners belonging to the same profession, there are significant differences in the ways they practice psychotherapy.

Among medical doctors, for example:

*Some include psychotherapy techniques in their medical practice, such as cognitive-behavioural modification or hypnosis. They may also oversee therapy support groups or imaginative suggestion techniques (with cancer patients, for example). The domains within which these are carried out are unmistakeably medical.

*Some give formal notice that they are practicing psychotherapy. They also provide these same psychotherapy patients with relevant medical treatments such as diagnosis, prescriptions for medications, hospitalization, and referrals for medical testing.

*Some others, in particular those offering psychoanalysis or psychoanalytic psychotherapy, delineate between their medical and psychotherapy services. They do not wish to "wear two hats" with the same patient or analysand

The challenges confronting those attempting to regulate psychotherapy can by this point be appreciated. The examples above reveal the intricate ways in which its practice is embedded throughout both regulated and non-regulated disciplines. One result is that no consensus can be reached as to what body of knowledge those training for it must be required to study. Without this consensus no regulation is possible. (An earlier effort to arrive at a consensus within the Ontario Society of Psychotherapists had to be abandoned).

III. Appropriate Regulation and Support of Psychotherapy in Ontario

A preliminary proposal: that the word 'unregulated', in view of its negative connotations in English usage, be phased out of the present discourse and replaced by 'non-regulated'.

Summary of Implications for Regulation

The previous section considered what psychotherapy is and how it is being practiced in Ontario at the present time with a view to thinking more critically and creatively about if and/or how it ought to be regulated.

Several implications for regulation were made explicit. They are reiterated here.

A. Because of its uniquely heterogeneous and multidisciplinary nature, the profession of psychotherapy cannot be regulated.

1. It cannot be placed under the aegis and regulatory power of any discipline because too much of its theory and practice would fall outside the competency of that discipline.

2. No consensus as to what training for psychotherapy must entail can be agreed upon. That applies to the body of theoretical knowledge as well as to the experiential components of its training.

3. Training for most psychodynamic modalities includes personal and experiential components that a university setting is not designed to provide.

B. Psychotherapy by its nature is grounded in civil liberties.

Most psychotherapy is voluntarily sought by people who are dissatisfied with the quality of their lives. They look for a trained person with whom they can speak about obstacles in their close relationships, in the workplace, and in their life choices more generally. They often experience a sense of emptiness in their lives, or of futility and inability to engage in fruitful ways in their communities. They often speak of their dissatisfaction as spiritual in nature. All of these complaints may be more or less acute and urgent. For the most part they do not entail serious or extensive dysfunctionality.

For the most part, these persons pay for psychotherapy themselves. Public funding is much of the time not being drawn upon--which removes a further incentive for intervention.

In the matter of adult persons' freedom to enter into a conversationally based psychotherapy with the professional of their choice, there can be no regulation. Psychotherapy is a helping service of a unique sort: however secular it may be, it shows its origins in religious and spiritual traditions, and very frequently those seeking it look for therapists familiar with their faith and/or culture.

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It is difficult to imagine informing the people of Ontario that they may speak of such personal matters only to practitioners with specified training. It is still more difficult to imagine warning them that to do so would be engaging in an illegal act.

In fact, in a discourse spurred by concern for protecting the interests of the public, it is striking how limited, if not absent, participation by the public is.

Apart from reporting unethical and indictable abuses, which clearly demand immediate redress, how does the public evaluate the performance of its psychotherapy practitioners? Without such feedback from the lay public, it is difficult to talk intelligently about the regulations and controls that would serve them.

C. There are other regulatory models for the practice of psychotherapy which are more well established and more appropriate.

The most important of these are the long established training institutions in psychodynamic psychotherapy. Over a century old, they are in fact the founding schools of the profession of psychotherapy. Furthermore, they continue to flourish and develop themselves not only internationally but also locally.

Recently (2001) the Canadian Association for Psychodynamic Therapy (CAPT) was formed as a cooperative vehicle to articulate and develop the practice of psychodynamic

psychotherapy in this province and country. Its first effort was to bring together the training institutes in Toronto. They are, at present:

*Adler School of Professional Psychology (ASPP)
*Centre for Training in Psychotherapy (CTP)
*Institute for Advancement of Self Psychology (IASP)
*Ontario Association of Jungian Analysis Training Program (OJATP)
*Toronto Institute for Contemporary Psychoanalysis (TICP)
*Toronto Institute for Relational Psychotherapy (TIRP)

Graduates, students and faculty of these member institutes are automatically accepted as members. So also are graduates, students and faculty of the following institutions:

*Toronto Centre of Psychodrama and Sociometry (TPCS)
*Toronto Child Psychoanalytic Program (TCPP)
*Toronto Psychoanalytic Society (TPS)
*Toronto Psychoanalytic Society Psychotherapy Training Program (TPSPTP)

Practicing psychotherapists who are not members of the above institutions may be sponsored for CAPT membership by CAPT members.

CAPT members represent all the disciplines, giving CAPT highly representative and fertile promise.

The form of training represented by these institutes offers a unique and alternative form of regulation.
It includes initial training, supervision and ongoing professional development. In particular, it offers the strength and richness of collegiality.
Collegiality provides the matrix for training in the particular approach, for peer supervision and consultation, for regulation and accountability of its trainees, and for collaborative professional development with its graduates.

All of these activities function within the guidelines of clear and established codes of ethics.

CAPT is also a member of the larger Ontario Coalition of Mental Health Professionals.

D. There is one regulatory principle that can be stated unequivocally:

This principle acts as an agent of alignment throughout the whole extent of psychotherapeutic practice.

Anyone setting out to practice any form of psychotherapy should first be trained to practice it

1. It reflects the traditional breadth of psychotherapy.
2. It encourages cooperation and mutual respect among psychotherapy professionals.

3. It discourages the tendency among some to import regulatory modes and requirements from related disciplines into the practice of psychotherapy, where they are neither universally applicable or requisite. This tendency has been a besetting problem in considerations of regulation.

4. It respects the training and experience of the large and diverse body of psychotherapists who are not members of regulated professions. They constitute a rich professional resource in the province. These psychotherapists are justifiably apprehensive about regulatory proposals that would effectively disqualify them from practicing.

5. It assures the public of access to the present spectrum of psychotherapy services, and it avoids gratuitously curtailing their choice of therapists.

6. It avoids the more odious elements of hegemony and coercion that vitiate certain regulatory proposals.

E **One of the areas that most needs attention in present-day practice of psychotherapy is providing therapists with regulatory and developmental supports after they have completed their training**.

These include:

1. Structures of accountability
2. Ongoing training and development resources that are indigenous, predictable and organized, so that practitioners may rely upon them to be consistent and financially feasible.
3. Collegial opportunities that are broader and more established.

There are encouraging developments in this regard, but they are still at an initial stage. Specifically, the members of CAPT are beginning to organize a a collective program that would give its members mutual access to selected components of their respective training.programs. The opportunities here for postgraduate development are promising.

It should be recognized in ending this brief that the professional ambience of psychotherapy practice in the larger Toronto area shows greater excellence, health and promise than it has ever enjoyed. Evidence of this can be found in

the quality of its training programs,
its increasing recognition of the need to train for the profession,
the growing cooperation among psychotherapists of different kinds,
and the progressive nature of its discourse.

Toronto is coming of age as a centre of psychotherapy, with very considerable resources to offer and exchange.

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