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.

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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' resists ordinary attempts at definition. because it is a category that refers only to a group as a whole.

The group is held together by a single name that, when translated from its Greek original, means the care, healing (*therapeia*) of the soul, mind, psyche *(psyche*).

As a professional term, this obviously covers a range of unmanageable size. It needs further specification. Dictionary definitions typically provide this

*by stating what is beyond the limits of the term: namely the practices of medicine, education, religious ministry, sport, parenting and so on (though all can be described as caring for the soul, psyche, mind).

*by typically including a list of examples of psychotherapy to show how the term is actually used. These lists, though they can go on for pages, are never exhaustive. The include psychoanalysis, play therapy, psychodrama, family and couples therapy, cognitive-behavioural modification, art and music and dance therapies, group therapy, transcendental meditation, etc.

No further *defining or essential* feature can be added to "the care/healing of the psyche/mind/soul." To do so is to risk excluding practices described as "psychotherapy."

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

'Psychotherapy' is a category that is characterized by 'family resemblance' rather than a common essence.

(Linguistic philosopher Ludwig Wittengenstein gives as a common example of this category the word '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).

That means there is no generic practice of psychotherapy.

Anyone practicing psychotherapy is always and only practicing one or a combination of its forms.

Psychotherapy" presents us with a range of almost unwieldy extension and heterogeneity, because this single term embraces the evolution of interrelated practices spanning over a century and still alive.
Some of its forms grow out of others. Some of these emerge in direct opposition to others. The grouping included in "psychotherapy" is both richly cross-fertilizing and "a bag of hammers."

The present discourse on the regulation of psychotherapy offers one of the few occasions when "psychotherapy" as the whole family comes under observation and discussion. 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.

Though the term psychotherapy resists clear definition, its specific forms can readily be identified and described.
It is only once they are, that psychotherapy can be meaningfully discussed.

The essential heterogeneity of psychotherapy poses unique challenges to regulatory interventions: 1) One cannot regulate a profession without first defining, or identifying and describing, what it is one wishes to regulate.
2) In the case of psychotherapy, a working definition must recognize explicitly that psychotherapy is a group term for practices ranging over a large spectrum both of modalities and of professional domains. Regulatory initiatives not grounded in a recognition of the essential and long established pluralism of psychotherapy end up caught in exclusions and contradictions.
3)They do harm to the quality and diversity that has evolved in psychotherapy.

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

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.

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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 trains them to practice psychotherapy.

Psychotherapy cannot be placed under the aegis of any one discipline. None of the disciplines of medicine, psychology, social work, education, religious/spiritual traditions, the arts, or philosophy are capable of assuming regulatory control over the spectrum of current psychotherapeutic practices
Psychotherapy cannot even be defined as one of the health services, for sometimes it is and sometimes it is not.

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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 efficacy of these long established structures of regulation cannot be overemphasized. They appear as uniquely valuable models to the work of ordering and improving psychotherapy practice.
Training and its regulatory twin, the collegial matrix of supervision and professional development, may be described as powerful health and prevention forces within psychodynamic psychotherapy.
Malpractice is correspondingly less likely to occur in such an ambience.

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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.
The fact that the entire training for cognitive-behavioural therapy can be offered in an academic setting also makes it attractive as a ready and promising candidate for regulation.
The same is not true, however, for training in most other forms of psychotherapy. Training for most psychodynamic modalities in particular 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 an intentional 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, both therapeutic modalities 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.

III. The practice of psychotherapy in Ontario today

The on-the-scene practice of psychotherapy in Ontario at the present time 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.

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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 adaptability and quasi-ubiquity across various health and humanistic services in the province are realities that the present discussion of regulation must take into account.

Psychotherapy owes its heterogeneity to the convergence of several differentiating principles:

1). There are distinguishing differences among those who enter psychotherapy:

A) 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.

B) 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.

C) 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.

D) 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
*clergy and lay ministers, who offer spiritual direction, or who act as chaplains in hospitals and prisons;
*actors and dancers;
*physiotherapists and occupational therapists, massage therapists, yoga teachers;
*teachers.

E) 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 choice of psychotherapy services in this (E) sector of the population in particular risk encroaching upon religious and civil liberties.

2. 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 A), B) and sometimes C).
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 an external forum.

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

In these instances the psychotherapy is typically carried out in public institutions and with public funding.
Typically, also, it is carried out by practitioners from regulated professions, such as medical doctors, social workers and psychologists.
It is regulated by virtue of respective professional association.

3. 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 unmistakably medical.

*Some doctors 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 examples given above reveal the intricate ways in which the practice of psychotherapy is embedded throughout both regulated and non-regulated disciplines. The challenges confronting those attempting to regulate psychotherapy according to existing models can by now be appreciated.

1. The major differentiation in psychotherapy practice described above bears on regulation. That is the distinction between psychotherapy offered in public institutions and/ or by regulated professionals paid by public funds, on the one hand; and on the other, psychotherapy offered by self employed practitioners and sought by persons paying for it themselves.

2. Because psychotherapy is pluralistic both in kind and in domain, 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. (For example, an earlier effort to arrive at a consensus within the Ontario Society of Psychotherapists had to be abandoned).

IV. Appropriate Regulation and Support of Psychotherapy in Ontario

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 psychotherapy and/or how it ought to be regulated.

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

1. Because of its uniquely heterogeneous and multidisciplinary nature, the profession of psychotherapy cannot be regulated according to models already in place.

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

2) There has been no consensus reached as to what training for psychotherapy generically considered must entail. Variation among experiential components will of course continue to characterize psychotherapy. However,

there is no consensus even with respect to the body of theoretical knowledge that should be required for all training in psychotherapy.

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3) Professional trainings carried out in public universities and colleges are the realm most unequivocally appropriate for regulation. However, training for much of psychotherapy practice includes kinds of learning and principles of evaluation that a university setting is not designed to provide. The personal and experiential nature of some components of training cannot be pursued in that ambience.

2. The ways psychotherapy is presently practiced in Ontario are profoundly modified by the setting in which it is carried out, and by the regulatory status of those practicing it.
There is a major boundary between psychotherapy provided by regulated practitioners (typically) in public settings and at public expense, on the one hand; and on the other hand, psychotherapy offered by self-employed practitioners in private practice and at the expense of those seeking it.
The same regulatory net cannot be cast over psychotherapy practiced in these two settings.

1) Services offered in public institutions such as hospitals, community health centres, rehabilitation centres, schools, and prisons—or in some association with them—usually require academic qualifications. These degrees were acquired under public regulation. They are also publicly recognizable. If psychotherapy is to be offered in such venues, its practitioners will usually be required to have particular academic degrees. Though these degrees may not always provide substantial training to do psychotherapy, they qualify individuals to practice in a particular professional domain.

2) The working milieu itself may demand training in a regulated profession such as medicine, law or psychology. The regulatory supports proper to these professions are therefore in force.

3) The public being served is typically less proactive in their choice of practitioner. Many, for example are children, are seriously disturbed, are addicted, or are required by the courts or their employers to enter the therapy. They are in these ways more dependent on their practitioners.

4) In the second sector of private practice of psychotherapy, its services are voluntarily sought by people who also pay for it. Their motivation, then, is noteworthy, as is the initiative they take to find persons trained in psychotherapy, and even in particular forms of psychotherapy. Academic qualifications of other kinds tend to be less emphasized. They may also want reassurance that the therapist has the supports of a professional association.
These are individuals who are dissatisfied with the quality of their lives. They want to speak about difficulties 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.

Public funding is much of the time not being drawn upon to pay for the therapy--which removes a major incentive for regulatory intervention.

Practitioners in both of the public and private sectors described may be practicing the same forms or modalities of psychotherapy, and be trained to do so. This is not the defining distinction.

3. Psychotherapy by its nature is grounded in civil liberties that cannot be threatened by regulatory interventions.

1) In the matter of adult persons' freedom to enter into a conversationally based psychotherapy with the professional of their choice and at their own expense, there should be no statutory regulatory intervention.

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.

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 informing them that they are engaging in a governmentally controlled act.

2) In fact, in an investigation spurred by concern for protecting the interests of the public, it is striking how limited, if not absent, participation by the public is. The public is being talked about, talked for, in the HPRAC documents. But there is a dearth of literature in which the public itself speaks.

Apart from reporting unethical and indictable abuses, which clearly demand immediate redress, how does the public evaluate the performance of its psychotherapy practitioners?

Without the involvement of the public "stakeholders" in the evaluation of psychotherapy in Ontario, it is impossible to talk knowledgeably about the regulations and controls that best protect their interests.

4. There are other regulatory models for the practice of psychotherapy which are well established and integral to many of its forms.

Among the most developed of these regulatory models are those that structure trainings in psychodynamic psychotherapy. 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.

5. It is therefore proposed that in the current discourse about regulation and psychotherapy, the word 'unregulated' be phased out .

Given its negative connotation in ordinary English usage, and one that is sometimes implied in the regulatory discourse, “unregulated” is misleading and prejudicial.

It should be replaced by the more accurate distinction between:
1) statutory regulation and 2) non-statutory self-regulation.

6. There is one regulatory principle that ought to govern the whole continuum of psychotherapy whatever its modalities and venues. It can be stated unequivocally:

ANYONE SETTING OUT TO PRACTICE ANY FORM OF PSYCHOTHERAPY SHOULD FIRST BE TRAINED TO PRACTICE IT.

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

1) It strengthens the traditional breadth of psychotherapy.

2). It encourages cooperation and mutual respect among psychotherapy professionals.

3) It discourages the tendency to import regulatory modes and requirements from related disciplines or particular forms psychotherapy into the practice of psychotherapy forms, where they are neither universally applicable or essential. 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) The profession of psychotherapy owes the public information about how wide the range of psychotherapeutic services are. Psychotherapy practitioners, including those in regulated professions, owe the public transparency about the particular nature of their own training.

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

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

1) Ideally, the regulatory and developmental supports described in the training institutions above (**4**) are made available to graduates in the professional associations of psychotherapists. Graduates of many training institutions also maintain strong connections with their schools.

2) However, these resources will flourish in a climate of ongoing training and development opportunities that exploit our considerable local expertise (avoiding the high expenses of travel, accommodation, and the hefty stipends of the famous). Opportunities for learning that are planned and therefore predictable mean that psychotherapists in Ontario can pursue ongoing professional development that they can rely upon and afford.

Collegial opportunities, such as seminars and peer supervision, that are more broadly based and use established resources are keenly sought by many psychotherapists.

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 collective program that would give its members mutual access to selected components of their respective training programs and to peer expertise. 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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