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International Journal of
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The International Journal of Psychotherapy is a leading professional and academic publication, which aims to inform, to stimulate debate, and to assist the profession of psychotherapy to develop throughout Europe and also internationally. It is properly (double-blind) peer-reviewed.

The Journal raises important issues in the field of European and international psychotherapy practice, professional development, and theory and research for psychotherapy practitioners, related professionals, academics & students. The Journal is published by the European Association for Psychotherapy (EAP), three times per annum. It has been published for 24 years. It is currently working towards obtaining a listing on several different Citation Indices and thus gaining an Impact Factor from each of these.

The focus of the Journal includes:

- Contributions from, and debates between, the different European methods and modalities in psychotherapy, and their respective traditions of theory, practice and research;
- Contemporary issues and new developments for individual, group and psychotherapy in specialist fields and settings;
- Matters related to the work of European professional psychotherapists in public, private and voluntary settings;
- Broad-ranging theoretical perspectives providing informed discussion and debate on a wide range of subjects in this fast expanding field;
- Professional, administrative, training and educational issues that arise from developments in the provision of psychotherapy and related services in European health care settings;
- Contributing to the wider debate about the future of psychotherapy and reflecting the internal dialogue within European psychotherapy and its wider relations with the rest of the world;
- Current research and practice developments – ensuring that new information is brought to the attention of professionals in an informed and clear way;
- Interactions between the psychological and the physical, the philosophical and the political, the theoretical and the practical, the traditional and the developing status of the profession;
- Connections, communications, relationships and association between the related professions of psychotherapy, psychology, psychiatry, counselling and health care;
- Exploration and affirmation of the similarities, uniqueness and differences of psychotherapy in the different European regions and in different areas of the profession;
- Reviews of new publications: highlighting and reviewing books & films of particular importance in this field;
- Comment and discussion on all aspects and important issues related to the clinical practice and provision of services in this profession;
- A dedication to publishing in European 'mother-tongue' languages, as well as in English.

This journal is therefore essential reading for informed psychological and psychotherapeutic academics, trainers, students and practitioners across these disciplines and geographic boundaries, who wish to develop a greater understanding of developments in psychotherapy in Europe and world-wide. We have recently developed several new 'Editorial Policies' that are available on the IJP website, via the 'Ethos' page: **www.ijp.org.uk**

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The IJP Website: www.ijp.org.uk

The IJP website is very comprehensive with many different pages. It is fairly easy to negotiate via the tabs across the top of the website pages.

You are also able to subscribe to the Journal through the website – and we have several different 'categories' of subscriptions.

You can purchase single articles – and whole issues – that are downloaded directly as PDF files by using the CATALOGUE on the IJP website (left hand side-bar). Payment is only by PayPal. We still have some printed copies of most of the recent Back Issues available for sale.

Furthermore, we believe that **'Book Reviews'** form an essential component to the 'web of science'. We currently have about 60 relatively newly published books available to be reviewed: please consult the relevant pages of the IJP website and ask for the books that you would enjoy reviewing; and – as a reviewer – you would get to keep the book. All previously published Book Reviews are available as free PDF files.

We are also proud to present a whole cornucopia of material that is currently freely available on-line (see box in top left-hand corner of the website). **Firstly**: there are several 'Open Access' books and articles, free-of-charge for you to read – if you wish; **next** there are an increasing number of free "Open Access" articles; **then** there are usually a couple of articles available from the forthcoming issue, in advance of publication. In addition, there is an on-going, online 'Special Issue' on **"Psychotherapy vs. Spirituality"**. This 'Special Issue' is being built up from a number of already published articles and these are now available freely on-line, soon after publication.

Finally, there are a number of previously published **Briefing Papers**: there is one on: *"What Can Psychotherapy Do for Refugees and Migrants in Europe?"*; and one on an important new direction: *"Mapping the ECP into ECTS to Gain EQF-7: A Briefing Paper for a New 'Forward Strategy' for the EAP"*. Because of a particular interest that we have in what is called by "Intellectual Property", we have also included a recent briefing paper: *"Can Psychotherapeutic Methods, Procedures and Techniques" Be Patented, and/or Copyrighted, and/or Trademarked? – A Position Paper."* Lastly, as part of the initiative to promote psychotherapy as an independent profession in Europe, we have: *"A Position Paper on the Nature and Policy Applications of Appropriate Psychotherapy Research"*, which we publish in this issue.

International Journal of Psychotherapy

Editorial

Courtenay Young

Editor, International Journal of Psychotherapy

Dear Readers, dear Colleagues, dear Members of the EAP,

This is our 25th year of publication! We have designed a new logo to go with the new EAP logo and banner (as above) and we are also redesigning the EAP website to go along with the colour-scheme of this new logo and banner. All this is quite an achievement, as I hope that you will agree.

We have also made the transition from an almost totally printed Journal (with 500 copies per issue) to much more of an accessible e-Journal. As a part of this transition – which has taken us two years (six issues), we have already had a "New Look for the IJP" accorded to us by our wonderful new typesetters.

We are also now getting our printed copies from "Print-on-Demand-World-wide", who will print – and distribute – as many printed copies as we require, whenever we require them. This also replaces the need for storage of any un-sold our Back Issues and maintaining an office. We are still having to catch-up a little and clear-up a little with this final step – and yet, we have high hopes that all these steps too will soon be completed. We are also catching up with our EBSCO library subscriptions – which provide us with some ready cash! We would like to thank everybody for their patience.

The hugely important point is that: **(i)** we have now almost caught up with our issues after the decision – out of the blue – by the EAP Board in February 2019 to cut 25% out of our production budget forcing us to implement all of these changes; and also, as a result of these changes, **(ii)** we are also now able to distribute the Journal to (about) 120,000 people across Europe: so there are some clouds that have silver linings, as they say!

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We calculate this figure thus: as we are encouraging our National Organisations, and our European-Wide Organisations, and our Ordinary Organisations, and our European Accredited Psychotherapy Training Institutes to send the e-issue of the Journal to all their individual members and trainees. All these people will get the Journal free-of-charge. We can do this now as our "printed" production and distribution costs have been reduced considerably.

So, we now enter into this new 'silver' (25th anniversary) era with a whole lot of opportunities and possibilities. We hope that all you new readers will become interested, not just in our achievements and our 'back catalogue' (which was recently 'valued' at (at least) USD $45,000 by some spuriously acquisitive publishing house) – but also to the future: of new "Special Issues"; of new "Special Collections"; and also of an on-going dialogue between the authors (who bravely submit their manuscripts), our Editorial Team (who steadfastly process them), and our readers (who hopefully 'digest' them). In this way, we – the Editorial Team – feel that we are contributing to the 'growth' of international multi-disciplinary psychotherapy.

Of course, we would like some more new 'institutional' subscribers, either from non-European countries, or from other psychotherapeutic modalities, or from other libraries and universities, so that the 'message' of this independent Journal is extended even further. We believe that we hold a unique place somewhere in between some of the massive multi-national publishing companies (Elsevier, Taylor & Francis (Informa), etc.), with lists of thousands of journals, who make a lot of their money from re-printing &/or downloading costs to readers of about $30 per article – their annual revenue figures are staggering [1] – on the one hand – and the 'new' batch of "scientific" e-Journals, who now feel able to charge their authors an "Article Processing Charge" of between $600 and $1,000 (so as to maintain their income and cover their production costs) – on the other. We charge €3.00 per article and about €12.00 per issue for back numbers and we do not charge authors any fees for publishing their articles. There are, of course, the much more localised, modality-specific, psychotherapy journals, who also struggle against this sort of commercial exploitation.

We wish to stay feel free – and we would also like to extend our interests towards (say): African psychotherapy; Asian psychotherapy, etc., as well as towards more intimate, scientific, qualitative research studies, (possibly) with limited populations, which are much more geared to the scientific study of psy-

1. **Elsevier** publishes more than 500,000 articles annually in 2,500 journals. Its archives contain over 17 million documents and 40,000 e-books. Total yearly downloads amount to more than 1 billion. It's 2019 revenue was £2.64 billion ($3,640,428,000). **Informa**, the parent company of Taylor & Francis, which also publishes books and other material, had a 2019 revenue figure of £2,890.3 million ($3,984,868,000) [source: https://www.informa.com/globalassets/documents/investor-relations/2020/20200310-informa-full-year-2019-results-statement---final.pdf]

chotherapy than the (qualitative) randomised controlled trials, etc. In this vein, we are publishing the latest EAP Briefing or Position Paper; this one is on the "Nature and Policy Applications of Psychotherapy Research": you can also find it on the EAP website (here [2]).

However, we do have one 'caveat' – we absolutely have to maintain a reasonably high degree of "scientificity" for any research articles. Such is the power of these international databases that we will not be given a proper "impact factor" unless we conform to 'this', or 'that', or the 'other', 'scientific' or 'academic' criteria: such is the world of international publishing. So – please – you can help us in several different ways!

- If you submit an article – please, please, please, read through the "Information & Guidelines for Authors" very, very carefully, It is situated under the "Authors" tab on the IJP website (here: http://www.ijp.org.uk/index.php?ident=e6c3dd630428fd54834172b8fd2735fed9416da4). This is up-dated regularly and is the 'definitive' version for any aspiring Author. It is very difficult for us (though it is getting easier after 25 years) to "reject" an article, just because it is obvious that the author has not read through this properly. We do not want to discourage authors; we welcome their contributions! But, please, please, please read through this "Information & Guidelines" – carefully, very carefully, very very carefully – **before** you submit an article. It saves us a lot of time and trouble and you, the authors, some distress.
- Secondly, we are being "required" to become a lot more stringent on how, why and when we accept – particularly – "**Research**" articles. We have – perhaps – been over-generous in the past as we have accepted "research studies", which are perhaps: **(a)** more suited to psychology, rather than psychotherapy; **(b)** of somewhat less than rigorous design (as we have wanted to support people "out there" doing research in psychotherapy) – but this has been somewhat to our cost, as it has lowered the acceptable level of research set by these multi-national databases; and it has encouraged degrees of "pseudo-science" and "publishing for tenure" or "prestige", etc. – i.e. some of the less desirable aspects of 'scientific' research in psychotherapy – a very 'human' science; and finally, **(c)** there is not really a very good 'bridge' over the chasm between research and clinical practice. What we really want tto encourage is "evidence-based practice" and "practice-based evidence" – and even the development of Practitioner Research Networks. So, all this has been somewhat like Ulysses, steering his ship between Scylla and Charybdis (the monster and the whirlpool).

2. **EAP website**: www.europsyche.org/

- Thirdly, one other way in which we can improve our level of citations is when people publish articles in **other** indexed journals that reference articles published in the IJP. So, if you are an author, as well as a psychotherapist, and if you do publish articles in other journals, please, please, please reference as many IJP published articles as you can. We have a pretty impressive list of articles that you can access or download from the IJP website here.[3] We are sure that you will be able to squeeze in one or two references to an IJP article.

Finally, I – currently as the 3rd IJP Editor in our 25 years of history – have 'carried' the IJP – almost single-handedly for the last 10 years. It has been an incredibly rich and invigorating process. However, I am beginning to feel that I need to institute something of a "gradual hand-over", or a "progressive 'passing' of the baton", or a gentle releasing of some of the editorial responsibilities to others, in an organic way of functioning: a "change process". That would be the ideal! It probably won't happen quite that way, but it is a nice dream. I have absolutely no regrets about what I have done; the extent of what I have done; and the implications of being something of a 'gentle' dictator, a dedicated editor, or – as some have kindly said - an exceptionally gifted person, being the right person, in the right place, at the right time. However, times change!

So, I am / we are beginning to look at some form of an editorial "progression" of influence and responsibilities. I am a strong believer in Wilhelm Reich's "Work Democracy" – so I encourage any of you authors & readers 'out-there' to "step forward" and then we will see what works – for you, and for us – in terms of your involvement in this Journal. I hope that I will be around for some (but probably not all) of the next 25 years to see these changes happen!

3. IJP Back Issues List on IJP website:
http://www.ijp.org.uk/index.php?ident=135debd4837026bf06c7bfc5d1e0c6a31611af1d

The Existential Therapeutic Competences Framework: Development and preliminary validation

Joel Vos

Abstract:

Background: This study aims to develop a competences framework for Existential Therapies, integrating perspectives from key authors, practitioners, and systematic empirical research. This framework may help to validate, justify, and improve training and practices.

Methods: Data-collection included identifying competencies reported in surveys on existential therapists world-wide, handbooks, reviews and online discussions between existential therapists and researchers. The framework was built by creating and naming groups and sub-groups amongst all the collected data via thematic analysis. Each of the competences was validated by searching for empirical research evidence. Twelve researchers and practitioners on Existential Therapies gave their feedback on this article.

Findings: We identified 476 competences, which were reduced to 56 sub-groups of competences which were categorized into 13 groups. The framework shared generic competences, and meta-competences with other therapy approaches. Additionally, Existential Therapies included existentially-oriented competences about assessment, phenomenology, therapeutic relationships, and the explication of existential themes.

Discussion: This competence framework of Existential Therapies may be used in the training and supervision of existential therapists, and by professional bodies and health authorities to identify and monitor critical competences. This framework should not be used rigidly as a check-box activity but as part of broader conversations.

Key Words: competence; skills; psychotherapy; counselling; guidelines

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Introduction

Every program in psychological therapies wants to give their students the best possible competencies in their work with clients (APA, 2006). Therefore, professional bodies worldwide have formulated competence frameworks for education and training, which may guide and optimise the learning experiences (BPS, 2014; BACP, 2020; UKCP, 2020). These frameworks include competences and competencies; competences describe what people can do, for example, in terms of measurable semi-standardised skills, whereas competencies describe how individual practitioners could actually achieve these standards in terms of specific behaviour (Stevens, 2013; Whiddett & Hollyforde, 2003). The professional competences frameworks in psychological therapies include benchmarks based on best practice and evidence-based competences. This means that the competences are not merely based on the subjective opinion of experts, but are also based on research evidence, and thus these therapy competence frameworks may fit the requirements of evidence-based medicine (Hoffman, Dias & Soholm, 2012). These benchmarks may guide trainers and supervisors to assess and facilitate their trainees' progress, as well as guarantee the highest quality of care that therapists and trainees offer their clients.

In 2006, the American Psychological Association called for establishing and implementing competence standards throughout the field of psychology, across all levels of applied training and professional practice (APA, 2006; Campbell *et al.*, 2012; Hope, 2004; Kaslow, 2004; Roberts, Borden, Christiansen & Lopez, 2005; Thomas, 2010). This has, for example, led to the publication of Competency Benchmarks (Fouad *et al.*, 2009), Competency Assessment Toolkit for Professional Psychology (Kaslow *et al.*, 2009) and practicum competences outlines (Hatcher & Lassiter, 2007). Competency frameworks have also been developed for many types of psychological therapies and psychopathologies, such as clinical psychology, cognitive-behaviour therapy and psychoanalytic/psychodynamic therapy (UCL, 2020). This includes a competence framework for humanistic therapy, which seemed to follow from previous studies on humanistic competences (Cain, 2016; Cooper, 2016; Farber, 2010, 2012; Roth, 2015; Vallejos & Johnson, 2019; UCL, 2020). Furthermore, the European Association of Psychotherapy (EAP) has developed a generic framework for the professional competences of a European psychotherapist (Young, Szyszkowitz, Oudijk, Schultess & Stabingis, 2013; see full results on: www.psychotherapy-competency.eu).

Some of the previous frameworks have been criticised, for example because some frameworks do not seem to be in line with the experiences of experienced therapists; this seems to suggest that some frameworks may reflect more a top-down deductive approach by academics and influential decision-makers than a bottom-up inductive approach summarising the subjective experiences of practitioners (Roth, 2015). Therefore, it may be argued that it may be needed to develop competency frameworks on the basis of both the expertise of key researchers ('top-down') and the experiences of therapists in the field ('bottom-up').

There is no comprehensive competences framework for Existential Therapies – although some authors have identified some critical competences in Existential Therapies (Hoffmann, Vallejos, Cleare-Hoffman & Rubin, 2015; Wong, 2016; Vos, 2017). It may also be argued that such a framework does not properly exist as Existential Therapies can be regarded (by some) as a sub-set of humanistic therapies, and thus these existential-therapeutic competences may already have been included in the humanistic competences framework.

However, there seems to be an increasing awareness that, although there are significant overlaps between humanistic and Existential Therapies, there may also be some considerable differences (Cooper, 2016; van Deurzen & Arnold-Baker, 2018; Van Deurzen *et al.*, 2019). For example, some of the unique characteristics of Existential Therapies have been indicated by a world-wide survey amongst practitioners (Correia, Cooper & Berdondini, 2014; Correia, Cooper, Berdondini & Correia, 2017). Several authors have also published guidance on what they regard as the unique key skills in Existential Therapies (e.g. van Deurzen & Adams, 2005, 2016; Vos, 2017), and over 70 authors have published treatment manuals based on their selection of core competences (see overviews in: Vos, Craig & Cooper, 2015; Vos & Vitali, 2018). Many of these guidelines and treatment manuals seem to converge on first reading, but there has not been any attempt to formulate systematically a comprehensive competences framework, integrating the top-down views from key authors and also the perspectives of practitioners on the broader field. Furthermore, many of the authors in the field of existential therapy seem to base their critical competences on their – invaluable – clinical experience, but relatively less on systematic reviews of research; therefore, there seems to be a relatively limited empirical basis for the existential-therapeutic competences that these authors may have identified.

The development of a competences framework for Existential Therapies seems particularly timely, given the establishment of new training programs worldwide in Existential Therapies since the turn of the millennium. A competences framework can guide the development of the curriculum, and also the formulation criteria for new professional bodies, such as the Federation of Existential Therapies in Europe (FETE).

Existential therapists can seem to be tardier than therapists in other therapy fields in identifying key skills, formulating competences frameworks, and engaging with quantitative research in general (Vos, Cooper, Correia & Craig, 2015, 2015a). This seems to have been caused by a reluctance, possibly inherent to existential philosophy, in reducing the complexity of the subjectively lived-experiences of the therapeutic encounter into specific skill categories and numbers. Developing an evidence-based competences framework for Existential Therapies may therefore be regarded a '*contradictio in terminis*'. For example, the existential philosopher Martin Heidegger (1997) described how truth appears differently in different eras (épochе), and in our era it often seems to emerge via calculating thinking ('*rechnendes Denken*'). This is in line with the philosopher Wilhelm Dilthey (1895) who described a difference between 'explaining' psychological phenomena with external instruments and objective observation ('*erklären*') and 'understanding' from within the individual's subjectively lived experience ('*verstehen*'). When we try to explain the experience from the perspective of the therapist or researcher, we may miss some crucial aspects of the experiences of the client and the interaction, and thus we may be imposing our ideas on the other instead of doing justice to the otherness of the other (Levinas, 1961). If we zoom out, we also see that the modernist idea that we can achieve absolute truth at all has been questioned by several post-modern existential therapists, and thus they seem to criticize the idea of constructing universal frameworks (Loewenthal, 2018).

Furthermore, Heidegger (1914) argued that scientists nowadays dominantly ask the questions 'what' something is and by 'whom' this is created, and they seem to forget asking many other questions (Vos, 2020a). For example, therapist competences frameworks seem

to focus on describing which individual therapist does precisely what action and the frameworks seem to pay relatively less attention to the questions 'how' the therapist achieves this (e.g. therapeutic process and relationship) and 'for what purpose'. Thus, competence frameworks – and possibly evidence-based medicine in general – seems to be based on a functionalist approach, which seems to reflect our contemporary dominant functionalistic and materialistic paradigms in politics and economics (Vos, 2020). Thus, this functionalist framework may not do justice to the complexity and dynamics of the subjectively lived-experiences of clients, therapists, and their interaction and context (Vos, 2020a).

Whereas it seems ideologically admirable to reject rigid operationalisation and categorisation of existential therapeutic competences, this may not be pragmatic and beneficial for the professional status of Existential Therapies. As many health-care providers and insurances require professional competence frameworks for training and practice, and – without such frameworks – they may exclude Existential Therapies from their smorgasbord of funded treatments. A competences framework may also support the learning efficiency in existential therapy programs and stimulate a critical self-reflection and reflexivity in trainees regarding their practices.

Furthermore, seen from a pragmatic-phenomenological perspective (Vos, 2013, 2017, 2020a), a competences framework may not offer the sole and ultimate perspective on therapies. The phenomenon of therapeutic practice may be compared with a multi-faceted diamond and a competence framework is like light cast from one angle, making only one specific facet shine while leaving other facets in the dark. Similarly, other frameworks – such as the post-modern rejection of operationalisation – may also only reveal a limited number of facets (Vos, 2013; Vos, Cooper, Correia & Craig, 2015, 2015a). We seem to be needing to cast lights from multiple angles in order to be able to understand the totality of the phenomenon – as seen from a hermeneutic-phenomenological perspective – like Gadamer's (2004). A light that comes from merely one angle – whatever this angle may be – may not be sufficient to grasp the totality of the phenomenon of the therapeutic encounter. Thus, it may be epistemologically justifiable – and clinically pragmatic – to develop a competences framework for Existential Therapies while we explicitly acknowledge its limitations.

Therefore, this study aims to develop a competences framework for Existential Therapies, which integrates both 'bottom-up' and 'top-down' perspectives and is based on systematic empirical research. This framework may help – pragmatically – validate, justify, and improve Existential Therapies' training and practices. This framework may, for example, help in the United Kingdom to translate Existential Therapies in terms of the National Occupational Standards (NOS) for mental health care workers (www.skillsforhealth.org.uk) and the Improving Access to Psychological Therapies (IAPT) programme (Vos, Roberts & Davies, 2019).

Methods

1. ***What does a competences framework look like?*** In the fields of Human Resource Management and occupational training, many formats have emerged over the years (Fretwell, Lewis & Deij, 2001; Lucia & Lepsinger, 1999; Sanghi, 2016; Whidett & Holyforde, 2013). Most psychotherapy competence frameworks seem to include the following components (Roth, Hill & Pilling, 2009): **Generic Competences** (all psychological therapists should have these); **Basic Competences** (all existen-

tial therapists should have these); **Specific Competences** (individuals within specific existential therapeutic schools should have these); and **Meta-competences** (competences used by therapists to work across all levels, to adapt Existential Therapies to the needs of each individual client).

To facilitate the use of a competences framework – for example in the assessment, supervision and guidance of trainees – we have decided to provide anchors on five different levels for each competence: beginner's level (level 1), intermediate level (level 3) and advanced level (level 5); level 2 can be described as 'beginner's level, on the way to intermediate level', and level 4 can be described as 'intermediate level, on the way to advanced level' (cf. Meaning-Centred Practitioners' Skills Questionnaire in: Vos, 2017).

2 ***How can a competences framework be developed?*** Most authors seem to develop competence frameworks in four stages, which we will follow in this study (*ibidem*).

Preparation stage: This includes defining the aims for the framework, and differentiating this from other frameworks, as already described above.

Data-collection stage: This usually includes the collection of data with a bottom-up approach, such as observations, interviews, and surveys of practitioners, as well as top-down reviews of what key authors have identified as critical competences. Specifically speaking, we will collect data in three ways.

First, we will identify the competences that have been reported in surveys on the world-wide characteristics of existential therapists (Correia, Cooper & Berdondini, 2014; Correia, Cooper, Berdondini & Correia, 2017).

Second, we will identify competences that have been mentioned in key handbooks and reviews of the field of Existential Therapies; these books have been selected on the basis of the frequency that they have been cited, and the breadth of their scope, such as describing as many different existential-therapeutic schools as possible (Cohn, 1997; Cooper, 2015, 2016; DuPlock, 1998; Edelstein, 2014; Hoffmann, Vallejos, Cleare-Hoffman & Rubin, 2015; Holzhey-Kunz, 2014; Iacovou & Weixel-Dixon, 2015; Langdridge, 2013; Langle & Kuntz, 2008; Langle & Wurm, 2018; Lantz & Walsh, 2007; Lukas, 2000, 2019; Marshall, 2012; Rayner & Vitali, 2018; Russo-Netzer, Schulenberg, & Batthyany, 2016; Schneider, 2016; Schulenberg, 2016; Spinelli, 1994, 1997, 2014; Strasser & Strasser, 1997; van Deurzen *et al.*, 2019; van Deurzen & Arnold-Baker, 2005, 2018; van Deurzen & Adams, 2016; Vos, 2016, 2016a, 2017; Wong, 2013, 2016; Yalom, 2020).

Three, we will identify the competences that have been reported in two online discussions between key existential therapists and researchers: a debate on key characteristics of existential therapy (in: Vos, Craig & Cooper, 2015), and a debate after the first World Congress of Existential Therapies, regarding the definition of Existential Therapies (www.existentialpsychotherapy.net, 2015; see Appendix 1). Each competence will be described in unique and operationalizable terms (i.e., observable and measurable). All publications in the data collection will be selected on the basis of this definition; only competences linking to this definition are included. As several of these publications are already based on systematic reviews of the literature, it is decided that it is unnecessary to conduct a new literature review.

Framework building stage: This stage involves creating and naming groups and sub-groups of all the pieces of information. We will do this via reflexive thematic analysis (Clarke & Braun, 2018). Practically speaking, this means that each competence in the previous step will be written on a Post-it note; in this step, all post-it notes are categorized to create a limited number of groups and sub-groups. All Post-its are included in the final model.

Validation stage: This means that each of the competences is scrutinized for their effectiveness. We will validate the framework in two ways.

First, we will systematically search for empirical evidence for the effectiveness of each competence. We will use existing reviews of the research evidence of Existential Therapies, and search for new empirical evidence for each competence (see reviews: Vos, 2016, 2016a, 2017, 2019; Vos & Vitali, 2018).

Second, we will ask authors and practitioners in the field of existential therapy, from different existential-therapy 'schools', to give feedback on this article. Each invited participant needs to have published at least one article or book on existential therapy and needs to have more than five years of clinical experience. In total, 12 therapists gave their input to this article: 4 identified themselves as "meaning-centred" therapists; 4 as "phenomenological-existential therapists" (the British School); 2 as "humanistic-existential" therapists; 1 as a Daseins-analyst, and 1 as integrative-existential therapist. Additionally, seven of these therapists were from Europe, three from the USA, and two from other continents.

The therapists were asked to rate for each of the competences: (a) relevance for professional practice; (b) importance for the clients; (c) frequency of use; and (d) importance for training of new therapists (range: 1 [not at all] – 5 [completely]); subsequently, they could add any comments and suggestions for better formulations. Overall, all competences were rated relevant for practice and important for clients and were used frequently (means > 3). These suggestions helped to refine the descriptions in this article, sometimes followed up with an email conversation, but their feedback did not lead to any significant changes to the content, and therefore their contribution is not further specified in this article. Future studies should include more therapists and examine how frequently each competence is used in practice, for example, via large-scale surveys.

Stage of implementation and continuous evaluation and improvement: This stage includes the application of the framework in the training and practice of existential therapists. This stage will not be described in this article, but recommendations will be made at the end of this article.

Findings

Process: In the data-collection stage, we identified 476 competences in the publications. Due to the overlap between competences, we were able to reduce these to 56 sub-groups of competences, which were categorized into 13 groups (see Figure 1). These groups were subsequently differentiated into Basic and Specific Existential Therapeutic Competences, and a group of Generic therapeutic competences, and a group of Meta-Competences were added (cf. Roth, Hill & Pilling, 2009). For the basic existential therapy skills, it was decided to use the names of the four competence groups that were identified in a world-wide survey on

Existential Therapies: (i) phenomenological, (ii) relational, (iii) explication of existential themes, and (iv) school-specific competences (Correia, Cooper & Berdondini, 2014; Correia, Cooper, Berdondini & Correia, 2017). Several competences also overlapped with the previous review of meaning-oriented therapies by Vos (2017) and therefore similar terminology was used. The worldwide survey did not reveal any existential assessment skills as a separate group of competences, but several authors specifically identified these as a separate group, and therefore this was added as a different group. Empirical evidence was found for each of the competences, although some competences are supported by stronger evidence than others, as will be described.

1a) ***Generic Competences***:

The following skills were identified in the literature and were categorised and named according to groups and sub-groups of the UCL Therapy Competency Frameworks (see details in: Roth, Hill & Pilling, 2009). This overview of generic competences also includes all 'Core Competences of a European Psychotherapist'; some of the latter competences will not be included in this section on generic competences, but in the sections on meta-competences (Young, Szyszkowitz, Oudijk, Schultess & Stabingis, 2013; EAP, 2013).

1b) ***Generic knowledge***:

This includes knowledge of mental health problems, in general, and, in particular, of problems within the specific work setting. This also comprises knowledge and application of professional and ethical guidelines, including following: the expectations regarding establishing a professional and safe working environment/practice/office, behaving professionally, recording information, managing workloads, maintaining support systems, developing and sustaining good relationships with colleagues, team members and other professionals, and engaging in continuing professional development. This generic knowledge also includes an understanding of the general theories and research on treatment via psychological therapies. Cultural competences describe the ability to work with individuals from a diverse range of backgrounds, such as knowledge and application-of-knowledge, regarding cultural and social differences, as research shows the positive effects of such cultural competences (Norcross & Wampold, 2019).

1c) ***Generic relational skills***:

This includes the capacity to build and maintain a constructive therapeutic relationship, as research shows that the therapeutic relationship is an essential therapeutic factor that may improve the effectiveness (Norcross & Wampold, 2019). Examples of establishing a good working relationship can include: having a clear communication style; clearly defining the therapists' and clients' roles; identifying and working towards mutually agreed and achievable goals; agreeing on responsibilities; establishing a relevant set of perspectives; expressing empathy and understanding; and establishing a therapeutic presence (EAP, 2013). Maintaining a psychotherapeutic relationship can include: respecting and valuing the therapeutic relationship; establishing self-awareness; communicating appropriately; managing the process of change; out-of-session contact; holidays; and breaks (*ibidem*).

Another important skill is the ability to cope with relational difficulties. This includes: repairing alliance ruptures, which are tensions or break-downs in the col-

laborative relationship between client and practitioner; a wide range of skills may be used to solve these, such as acknowledging the problem, exploring possible causes, finding solutions, and apologising when needed. Therapists must be able to end therapy in a way that is beneficial for the client (Roth, Hill & Pilling, 2009). This can include: preparing the client for completion of psychotherapy; exploring feelings about endings; identifying risks of difficulties after ending; managing the conclusion; reviewing the process; recording and evaluating the psychotherapy, managing sudden endings; and finishing the therapeutic relationship (EAP, 2013).

1d) ***Generic assessment***:

This includes the ability to: conduct a generic assessment of the main difficulties which concern the client, their history, their perspectives, their needs and their resources; an appropriate formulation of a diagnosis in evidence-based terms; their motivation towards a psychological intervention; and (based on the foregoing) a discussion of treatment options; and a monitoring of progress during therapy (Roth, Hill & Pilling, 2009). This also includes an assessment of any risks that the client may pose to themselves, or others.

1e) ***Generic supervision skills***:

The ability to use supervision includes: the capacity to arrange and engage in appropriate supervision; to be reflective and open to criticism; willing to learn; and willing to consider and solve any gaps in competences that may be revealed in supervision. Research indicates that supervision may help therapists to keep their work on track and to maintain good practice, regardless of the therapist's seniority.

2) Existential assessment competences

In contrast with the generic assessment competences, existential assessment skills focus on an assessment in terms of the unique clinical, aetiological, and therapeutic models of Existential Therapies (see Vos, 2019 for an overview of these models). Existential assessment competences partially overlap with relational and phenomenological competences as the assessment is conducted in a relationally constructive way (e.g. not patronising or stigmatising) and is based on a phenomenological assessment of the client's perspectives (e.g. not labelling and bracketing one's own assumptions).

2a) ***Knowledge of basic assumptions in existential philosophy and psychotherapies***: This includes: knowledge of existential philosophers; clinical, aetiological, and therapeutic assumptions in Existential Therapies; not only of one specific existential approach, but of all Existential Therapies, for example as reviewed by Vos in the *Wiley Handbook of Existential Therapies* (van Deurzen *et al.*, 2019).

2b) ***Exploring the client's existential needs & building an existential case formulation***: Although not all therapists explicate this step, many therapists seem to include an implicit or explicit assessment of the client's needs in non-reductionist terms. Research indicates that some treatments are more effective when these are based on a systematic assessment and case formulation (Page & Stritzke, 2006; Kendjelic & Eells, 2007). Case formulations may be used to determine, which treatment and interventions may best suit the client, and the guide the resolution of any problems during treatment (Teachman & Clerkin, 2016). A good case formulation should be as clear and as brief as possible, holis-

tic, precise, and empirically testable, and should be followed with research-based hypotheses about mechanisms of the aetiology and the treatment (Dawson & Moghaddam, 2015). In contrast with generic psychotherapeutic assessment, this assessment focuses on existential themes.

2c) ***Assessing the immediate needs and life situation of the client***: Being is 'being-in-the-world' (Heidegger, 1927), and therefore the client's problems, needs and resources need to be seen in the context of their 'life-world', including the material/physical/biomedical and social worlds in which they live. The assessment will explore systematically: their specific life situation; how this is related to their problems; and how they still find meaning in their daily life despite life's challenges. This may also include: an assessment of the client's relationship with the wider societal, political, and economic world in which they live, and which may have direct consequences for their physical daily life situation, personal and existential well-being (Vos, Roberts & Davies 2019; Vos, 2020).

2d) ***Using assessment at the start of the meaning-centred change process***: Whereas assessment in psychological therapies traditionally focuses on identifying the client's problems, existential therapists sometimes seem to try to find a balance with an assessment of strengths and resources. This may help prevent any iatrogenic damage from a negative-oriented assessment and may help the client explore possible solutions (Lukas, 2000, 2019).

2e) ***Using existential assessment tools***: Traditionally, existential therapists rarely use assessment tools such as questionnaires. However, increasing numbers of therapists seem to be using questionnaires in their assessment, although their employer or health insurance may require this. Therapists may use these questionnaires as a starting point for further conversation and not as a mere way to label or diagnose clients. Examples include: the Goal Attainment Form (GAF), which may facilitate the conversation about the aims of therapy; it seems that this form can facilitate any tailoring of the therapy (Cooper & Dryden, 2015).

3) Phenomenological competences

Phenomenological competences focus on the clients' subjective flow of experiencing (Vos, Cooper, Correia & Craig, 2015) and can help them gain deeper self-awareness and insight (Moran, 2000). Overall, research indicates that deepening experiential experiences may be beneficial and effective for clients (Elliott, Greenberg & Lietaer, 2004; Elliott & Freire, 2010).

3a) ***Phenomenological analysis of experiences***: Existential philosophical and therapeutic theories seem to have emerged historically in conjunction with phenomenological methods. However, existential therapists differ in the extent to which they explicitly apply a phenomenological approach – ranging from phenomenological therapists, such as Spinelli (1997, 2005, 2014), to meaning-centred psychotherapists, such as Breitbart (2015). Phenomenological competences can include: specific philosophical and Husserlian methods (1997, 2005, 2014), but also having a generic understanding stance towards the client (Vos, 2017). Many existential therapists seem to have developed their ways of applying phenomenology, such as: Langle, who follows four phenomenological steps (Langle, 2014); van Deurzen (2014) explores four worlds; and Spinelli (2015) identifies three phenomenological

steps. Reviews of clinical trials suggest that existential approaches, which are dominantly focused on phenomenological analysis, are less effective than approaches that integrate both phenomenological analysis and an explication of existential themes; integrative phenomenological / explication therapies also seem more effective than therapies that exclude an explicit and systematic phenomenological approach (Vos, Craig & Cooper, 2015; Vos & Vitali, 2018).

3b) ***Stimulating an attitude of experiential acceptance***: Existential therapists often seem to assume that psychological and existential problems may occur if individuals deny, or ignore, their subjective flow of experiencing and – for example, create fixated cognitive images about the world. Our images and thoughts may not do justice to the lived experiences of daily life and may even lead to frustrations and psychopathology. Therefore, one of the first steps in existential therapy often seems to be about facilitating clients to listen to their experiences, instead of suppressing these (e.g. Langle, 2014). This may be described as stimulating an attitude of experiential acceptance, that is:

> *'... accepting that we experience what we experience, being able to focus on experiences and trusting these experiences to show possible directions in life. Several practitioners have differentiated helpful from unhelpful experiential attitudes, which either help or block individuals from experiencing meaningful experiences.'* (Vos, 2017, p. 149).

This does not imply that clients need to accept the specific content that their experiences reveal to them, but it means that clients accept their experiences as a possible source of information that they need to take seriously. The clearest examples of stimulating experiential acceptance are possibly mindfulness and focusing (Gendlin, 1982).

3c) ***Stimulating clients to immerse themselves in the flow of meaningful experiences***: Frankl (1956) wrote that some clients may benefit from de-reflection, i.e. reflecting less and instead getting more into the flow of experiencing. As some clients seem to be stuck in their theoretical reflections (hyper-reflection) and their desires (hyper-intention). Several existential therapists seem to be helping clients to immerse themselves more into the flow of experiencing, instead of sitting passively on sedimented, fixated thoughts or images (Spinelli, 2005).

3d) ***Phenomenologically exploring hierarchies in the client's experiences***: Existential therapists do not only focus on experiences to help their clients accept their experiences and get into a flow, but also to deepen these experiences. At the core of phenomenology appears to be the process of unpeeling layers of our experiences, distinguishing the surface from deep levels of experiencing, and the more-meaningful from the less-meaningful (Vos, 2015, 2017, 2020). For example, via phenomenological explorations, a client may start to intuit how they could live a more meaningful and satisfying life despite life's challenges.

3e) ***Using a (Socratic) questioning approach***: Existential therapists often have a relatively non-directive approach, where they do not give direct answers to client's quests, but by asking questions to their clients that they support their journey of self-exploration (Vos, 2007). The therapist's role has often been compared with Socrates' metaphor of the midwife (*'maieutika'*), who can facilitate the birth

of something new, but who cannot do the birthing process themselves. Many therapists use a questioning approach (or Socratic Dialogue), although this approach may be applied in a loose way, or in a systematic way like Systematic Pragmatic Phenomenological Analysis (Vos, 2020a). Research suggests the benefits and effectiveness of Socratic Dialogues in therapies (in general) and indicates that this may also strengthen the working alliance (Britt, 2003; Overholser, 2011).

3f) ***Using specific and non-verbal exercises to focus on and explore experiences***: Existential therapists may use a variety of experiential techniques to help clients explore their experiences, such as focusing, mindfulness, meditation and guided imagination (see an overview in: Vos, 2017). It has been argued that the benefits of using specific exercises is that clients may be stimulated to explore their experiences in more focused and systematic ways, than if no specific exercises are used. Clients could also learn to apply these specific techniques in daily life. Research shows the benefits and effects of mindfulness and other specific experiential and non-verbal techniques (Elliott, Greenberg & Lietaer, 2004; Hofmann *et al.*, 2010; Khoury *et al.*, 2013).

3g) ***Stimulating expression of emotions***: In contrast, whereas some experiential therapeutic work may not need explicit theoretical reflection, in other situations, it may be important to do so. Therefore, phenomenological competences also include having the ability to help clients actively express and articulate emotions, make sense of experiences that are confusing and distressing and help clients to reflect on and develop emotional meanings.

4) Relational Competences

In contrast with the generic relational competences that therapists from any denominations should have, relational competences play a particularly important role in Existential Therapies. Relational competences focus on establishing an in-depth, authentic therapeutic relationship; along with reflection on, and analysis of, the relational encounter (e.g., Boss, 1963; Mearns & Cooper, 2017; Schneider & Krug, 2010; Spinelli, 1997; Yalom, 2001). This follows Buber's philosophy (2012) that authentic personhood is found in the in-depth encounter between two human beings. There seems to be the implicit assumption that clients may be able to deepen their experiences and explicitly work with existentially deep topics thanks to their deep therapeutic relationship; similarly, existential depth and relational depth may go hand-in-hand (Golovchanova, Dezutter, & Vanhooren, 2020; Vos, 2017). The world-wide survey (Correia *et al.*, 2015) suggests that there are four main categories of relational practices amongst existential therapists: **(i)** adopting a 'relational stance' (e.g. being present, caring, authentic encounter); **(ii)** 'addressing what is happening in the therapeutic relationship' (e.g. working in the here-and-now; **(iii)** being aware of one's reactions to the client, self-disclosure), relational skills (e.g. therapeutic listening) and **(iv)** person-centered skills (e.g. equal power relationship, unconditional positive regard). Empirical research strongly supports the emphasis on the quality of the therapeutic relationship (see review in: Norcross & Lambert, 2019). The following relational competences have been found amongst existential therapists and are supported by empirical evidence (Norcross & Lambert, 2019).

4a) ***Exploring the therapeutic relationship***: Existential therapists are able to work with the immediate relationship, including both conscious and unconscious processes. Working with the relationship may (for example) help the client to feel held and safe enough to express unwanted experiences and explore these at existential depth. Furthermore, although most existential therapists seem to lack a detailed theory and systematic approach about working relationally (like transference / countertransference in psychoanalytic / psychodynamic approaches), they explore the relationship as a possible source of information about how clients relate to other people in their life, in the present or past. The client may learn new insights and skills by examining the therapeutic relationship. This relational work seems to be a shift away from thinking about the client only in terms of their 'intrapsychic' presentation, and more towards to the notion of 'inter-subjectivity', seeing what emerges in therapy as a co-construction of ideas and meanings between both client and therapist (Roth, Hill & Pilling, 2009).

4b) ***Improving and deepening the practitioner–client relationship***: Existential therapists use many skills to strengthen and deepen the therapeutic relationship. Research suggests that practitioners who are experienced as more authentic, genuine, open or trustworthy seem to be slightly more effective (Orlinsky *et al.*, 2004; Burckell & Goldfried, 2006). Self-disclosure, whilst retaining professional boundaries, may sometimes be beneficial to the client (van de Creek & Angstadt, 1985; Hanson, 2005). (See also, Cooper & Mearns (2016) for examples how to work at relational depth in therapy.)

4c) ***Having a client-centred stance***: Many existential therapists seem to have a client-centred stance. This is based on Carl Roger's idea of the 'actualising' tendency (1962). Human growth is often believed to be self-directed, and thus the aim of the therapist's interventions would primarily be on the promotion of growth, through a rigorous focus on the issues and perspectives brought by the client. This also implies that the therapist should both take care not to introduce or to impose their own 'agenda' into the work, and also following the client's tempo in the process (Roth, Hill & Pilling, 2009).

4d) ***Empathising with the client's struggles in life and stressing that existential struggles are common to all human beings***: Many studies show the effectiveness of the therapists' empathy, i.e. their capacity to be open to, and absorbed in, the client's frame of reference, both via verbal and non-verbal communication (Norcross & Wampold, 2019). For existential therapists, this also means empathising with the client's struggles in life and normalising experiences, by stressing that existential struggles are common to all human beings.

4e) ***Recognising the importance of existing meanings, religious and cultural context***: Therapists in different approaches often offer an unconditional acceptance of clients, albeit that this attitude may have different names, such as "unconditional positive regard", "non-possessive warmth", "prizing, respecting, affirming and valuing the client's humanity" (Roth, Hill & Pilling, 2009). This also implies that therapists acknowledge and respect the client's unique meanings, religion, spirituality, and culture. However, whereas therapists from non-existential approaches may not explicitly explore the client's fundamental meanings and values in life, this may well be a legitimate

part of existential therapy. This involves a fragile balancing between respecting the client's frame of reference and not imposing the therapist's perspective, on the one hand, and exploring the role of the client's meanings in their self-development, on the other.

4f) ***Helping the client to develop ethical and authentic relationships and having an ethical stance towards the client and their situation***: Although existential therapists will naturally respect the client's unique perspectives, they may also stimulate clients to engage in ethical and authentic relationships, instead of – for example – in harmful relationships. This also implies that the therapists themselves have an ethical and authentic stance towards the client.

5) **Competences about explicating existential themes**

In general, existential psychotherapists often seem to offer didactical psycho-education regarding the topics that are explored in the therapy sessions (e.g. awareness of patterns in the client's history; education to avoid repetition of problems; promoting change in the client, within-their-social-context; and creating awareness of the aetiology, prevention and solution of mental health problems) (EAP, 2013). It seems that existential therapists fairly obviously focus their didactic skills particularly on existential themes.

That is to say, many existential therapists report practices that are explicitly informed by existential assumptions, such as explicitly addressing life's givens, such as freedom, choice, responsibility, being-in-the-world, mortality, existential anxiety and uncertainty of being (Vos, Cooper, Correia & Craig, 2015). For examples, logotherapeutic and meaning-centred therapies directly address the client's 'meaning-in-life' (Frankl, 1946; Breitbart *et al*., 2010; Langle & Wurm, 2018; Vos, 2017). The explicit 'naming' and exploring existential themes often involve a fragile balance with the phenomenological and relationally-accepting stance, as the explication should not come at the cost of the phenomenological or relational processes. For example, clients are invited to explore explicitly their world-views, their ways of relating to life, and their authentic being (Spinelli, 2005; van Deurzen, 2014). Reviews of clinical trials indicate that explicating existential themes, while maintaining the phenomenological and relationally-accepting stance, can be very effective for clients (Vos, Craig & Cooper, 2015; Vos & Vitali, 2018). More evidence for the effectiveness of addressing existential issues in therapy can be found in other therapeutic approaches, such as 'schema therapy' and 'acceptance and commitment therapy (ACT)' (e.g.Hayes, Luoma, Bond, Masuda & Lillis, 2006) and other positive psychology interventions (Lopez & Snyder, 2011; Seligman, Steen, Park & Peterson, 2005; Sin & Lyubomirsky, 2009). It has been argued that explicating existential themes may be particularly helpful for clients in existentially challenging situations – 'boundary situations' – in life, such as with cancer patients and those in palliative care contexts (Henoch & Danielson, 2009; Vos, 2016a).

5a) ***Recognising, naming, and exploring the existential dimension in the clients' experiences***: A core skill for Existential Therapies is identifying and, where appropriate, explicating or naming existential themes in the client's moods, behaviours and the unspoken experiences of the client (Vos, 2017). 'Recognising' means that therapists explicitly recognise the existential

reality of the client: 'naming' means giving a name to existential themes or moods (e.g. "*How would you describe these experiences?*"; "*Others have called this 'death anxiety*"); "exploring existential themes in the client's experiences" may include a questioning approach or existential-experiential exercises (such as the 'death-bed thought experiment'; Yalom, 1980).

5b) ***Stimulating meaning-centred coping with situations of suffering***: Existential therapists recognise that suffering is unavoidable for all human beings, and that avoidance or denial of feelings of suffering may be unhelpful for clients (Vos, 2019). Nobody can outrun the 'tragic triad' of suffering, death and guilt (Frankl, 1989), and our positive intentions may inevitably be confronted with injustices, paradoxes and failures in endless numbers of boundary situations (Jaspers, 1919). Trying to change the unchangeable, and fighting the unfightable, might even be unrealistic, ineffective, and even counterproductive. Unrealistic expectations of a problem-free life can lead to frustration and suffering, as these expectations will inevitably fail in daily life (van Deurzen & Adams, 2011). Therefore, existential therapists often seem to follow Niebuhr's 'Serenity Prayer' by trying to accept what we cannot change, having the courage to change we can, and building the wisdom to know the difference. Several existential therapists also explicitly help their clients to give a meaningful answer to their suffering – this does not imply that we are saying that there is no suffering, but more like finding ways to live a meaningful life, despite life's challenges (Vos, 2017). Frankl (1948) described, for example, how he was able to 'transcend' the horrors of his imprisonment in Auschwitz by focusing on what remained meaningful in his life. Since the turn of the millennium, many studies in health psychology have shown how 'meaning-oriented' coping can be an effective response in existentially threatening situations, such as having a chronic or life-threatening physical disease (Vos, 2016a, 2020b).

5c) ***Exploring paradoxical feelings about meaning, and fostering acceptance***: According to many existential therapists, life often brings us in paradoxical, ambiguous, and ambivalent situations (Jaspers, 1919; van Deurzen, 2014; Vos, 2014). For example, Frankl (1948) described how he needed to focus on something meaningful that could help him get through some of humanity's desolate situations in the concentration camp. There are often no black-or-white solutions to life's ailments, and any attempts to simplifying life's complexities may lead to frustration (van Deurzen & Adams, 2011). Therefore, existential therapists often explicate paradoxes in their client's experiences, and help them to tolerate these tensions – instead of immediately pushing these away. They may help clients to live a meaningful and satisfying life, while recognising the existential reality of life's challenges.

5d) ***Identifying avoidance and denial of existential topics, and flexibly tolerating existential moods***: 'Research on Terror Management Theory' has shown how the confrontation with life's ultimate boundaries, such as our mortality, can create existential anxiety, which individuals may try to deny or transform (Greenberg, Koole & Pyszczynski, 2014). On the one hand, temporary and partial denial of life's 'givens' may give some stress-relief in the short-term, or may even be a source for creativity and productivity; on the other hand, long-term and structural denial may lead to a lower life satisfying and the develop-

ment of psychopathology (Jim *et al.*, 2006; Vos & De Haes, 2007). Some existential therapists, such as Irvin Yalom (1980), explicitly work with existential defence mechanisms in therapy – like an existential version of psychoanalytic defence mechanisms. Existential therapists seem to differ in the extent to which they explicitly use this model of existential defence mechanisms, as some therapists reject the formulation of universal mechanisms and see this as imposing the therapist's models onto the client's experiences. Existential treatments that address life's 'givens' and existential moods, without simultaneously addressing meaning, have few or no significant effects in clinical trials than those that stimulate a dual attitude of experiencing meaning while recognising life's limits and paradoxes (Vos, 2014; Vos, Craig & Cooper, 2014).

5e) ***Stimulating clients to take up their responsibility for living a meaningful life***: On the one hand, existential philosophers have given much attention to the experience of freedom in life: being-there is being-in-opportunities (Heidegger, 1927). On the other hand, the topic of freedom also brings responsibility in life. Therefore, in line with Sartre's call to prevent 'bad faith', existential therapists often help clients to take up their responsibility for living a meaningful life. This message to clients "to be responsible for themselves may be found in many different shapes in existential therapy, such as preventing dependency in the therapeutic relationship, or preventing structural denial of life's givens.

6) **School-specific existential competences**

The previous sections have described competences that therapists in different existential schools may have in common. However, different existential schools may also involve slightly different competences. Authors have often identified four primary schools (Cooper, 2016; van Deurzen *et al.*, 2019): these are 'Daseinsanalysis'; 'Existential-phenomenological analysis' (sometimes called 'The British School'); 'Existential-humanistic / existential-integrative therapies'; and 'meaning-oriented' therapy, 'logotherapy' and 'existential analysis'. Each of these schools may have slightly different clinical, aetiological, and therapeutic assumptions, and thus existential-therapists will know the specific assumptions in their school and competences in school-specific assessment and explication of existential themes (Vos, Cooper, Correia & Craig, 2015).

Reviews of clinical trials have only provided strong empirical evidence for 'meaning-oriented' therapies, although the lack of evidence may be due to a lack of studies. Whereas only small or non-significant effects were found for other existential-therapeutic approaches, seventy clinical trials have shown that 'meaning-oriented' therapies can reduce the client's level of psychological stress and psychopathology and improve their quality-of-life (Vos, Craig & Cooper, 2015; Vos & Vitali, 2018). An overview of the common denominator of the treatment manuals of 'meaning-oriented' therapies shows the following specific evidence-based 'meaning-oriented' competences (Vos, 2016a, 2017): providing 'meaning-centred' didactics; focusing on 'long-term' meaning, instead of 'short-term' gratification and pleasure, and revealing the potential benefits of this focus; identifying and explicating 'meaning-centred' topics in clients' experiences; offering clients a guided discovery of

their meaning potential, via specific exercises; showing an unconditional positive regard about the possibility of finding meaning; addressing the totality of possible meanings in the client's life; concretising and specifying meaning in daily life; stimulating effective goal-management; stimulating the client to connect with the larger temporal experience of past–present–future legacy; exploring meanings in the client's past, as a potential source for improving self-esteem, hope and inspiration for future meaning; stimulating the client to give an independent but connected answer to the social context; focusing on meanings that are based on and that stimulate self-worth and self-compassion.

7) Meta-competences

Meta-competences are competences that therapists use to adapt the therapy to the needs of each client in each unique moment. Although there is an overlap with the generic skills that therapists have in all modalities, these meta-competences seem to have a more explicit role in Existential Therapies (e.g. Cooper, 2016). There is also an overlap with the relational competences of existential therapists, although meta-competences focus mainly on the therapist's explicit reflection and explication of these. Existential therapists have many of these meta-competences in common with other humanistic therapists. Several of these meta-competences have also been identified in the framework of Professional Competences of a European Psychotherapist (EAP, 2013). Although many humanistic therapists seem to agree with the importance of these meta-competences, little empirical research has been conducted into these (Roth, Hill & Pilling, 2009).

7a) ***Tailoring the therapy aims and methods to the client's needs, skills, and wishes***: There is not a general cook-book giving the perfect recipe for work with all clients. Individuals differ in their experiences, needs and resources. Therefore, existential therapists find it important to tailor the aims and methods of the therapy to the specific needs, skills and wishes of the client.

7b) ***Therapeutic flexibility***: This is the ability to respond to the individual needs of a client at a given moment in time, such as coping with change, difficult moments, trauma and crisis. The interaction of a particular therapist and a particular client may produce dynamics unique to that therapeutic relationship, resulting in context-dependent challenges for the therapist. In other words, in psychological therapy the problems to be addressed can present differently at different times. The therapist's contextual meanings and the client's actions change and the therapist is engaged in a highly charged relationship that needs to be managed. Therefore, what is required is a range of methods and approaches and complex interpersonal skills, under the guidance of very sophisticated mental activities' (Roth, Hill & Pilling, 2009).

7c) ***Meta-communication and shared decision-making***: This tailoring process is a collaborative process, whereby therapists and clients work together in formulating possible therapy aims that are meaningful to the client and methods that would fit their skills and preferences. This includes meta-communication and negotiation about the therapy process and sharing information with the client about which aims and methods may be feasible (Cooper & Mearns, 2016). Existential therapists seem particularly sensitive for possible power disbalances in the thera-

peutic relationship, and attempt to empower clients in the therapeutic process. For example, the generic assessment and the existential assessment should lead to the formulation of an explicit or implicit 'contract' with a client (e.g. formulating main issues, goals, motivation and need of therapy intensity, and referring to other professionals if needed: see details in the Specific assessment competences) as well as creating a tailored therapy plan with the use of therapy research and theory (www.psychotherapy-competency.eu).

7d) ***Capacity to adapt interventions in response to client feedback***: Clients may be asked explicitly to give their feedback about the therapy and the therapist, for example by explicit invitation by the therapists or by questionnaires (e.g. Cooper & Mearns, 2016). Therapists have the ability to adapt the interventions in response to this feedback.

7e) ***Capacity to use clinical judgment when implementing treatment models***: On the one hand, therapists are able to maintain adherence to a therapy school without inappropriate switching between modalities when minor difficulties arise. On the other hand, therapists are able to balance the adherence to a model against the need to attend to any relational issues that present themselves (Roth, Hill & Pilling, 2009). Thus, therapists are able to use their clinical judgment in the implementation of the treatment model.

7f) ***Self-reflection and reflexivity***: Since the hermeneutic turn in phenomenology, self-reflection and reflexivity fulfil a vital role in phenomenological analysis. Self-reflection regards reflections on one's self and their own existential and psychological development (for example, via personal therapy). Reflexivity means (etymologically) 'bending back upon oneself'. This may be explained as a form of critical self-reflection about the intersubjective dynamics between the therapist, client, and context. Reflexivity recognises the roles and positions of both the therapist and the client in the therapy setting and in the broader institutional/societal/political/global context (Finlay & Gough, 2008). This could, for example, involve reflexivity on the role of the organisation of the mental health care system (Vos, Roberts & Davies, 2019) or of the wider economy and politics (Vos, 2020). Although many existential therapists recommend reflexivity, few seem to elaborate how to engage in *systematic* reflexivity (Vos, 2020a).

Discussion

Since the turn of the millennium, a competence movement has emerged from within the field of psychological therapies. Therapies have started to move *"away from a knowledge base to a competencies base"* (Nelson, 2007), which meant *"a major paradigm shift in culture toward an approach that is devoted to providing outcomes-based education and training"* (Rubin *et al.*, 2007). Whereas competence frameworks have been developed for other therapies, this had not yet been developed for existential therapists, possibly due to ideological criticism and rejection of a functionalistic reductionism. We have seen in this article how a competence framework for the Existential Therapies can be developed, which may do justice to some of these criticisms, as long as these competences are not reified or made into a rigid tick-box activity. This existential competence framework seems to go somewhat beyond the various existing competence frameworks for psychotherapists, although it shares some of the generic competences and meta-competences (Roth, Hill & Pilling, 2009). As in addition to

other humanistic therapies, Existential Therapies also seem to involve existentially-focused competences about assessment, phenomenology, therapeutic relationships, as well as the explication of existential themes.

This framework may provide a clear set of competences to guide and refine the structure and curriculum of Existential Psychotherapy training programs and to have formulated and reasonable anchors as "end-points" of the training. This framework may also be used to assess trainees' progress and identify potential areas of improvement for individual trainees. This framework may also be useful in clinical practice supervision, which is usually provided to all psychotherapists at all levels: for example, to improve the performance of the practitioners and improve the outcomes for clients. However, there is often a wide variation in the quality of supervision and the competencies that individual therapists address (Elkin, 1999). Therefore, the systematic use of this competence framework may also potentially help supervisors to address relevant competences in their supervisees systematically. This implies a sort of "log-book", particularly for trainees and newly qualified therapists wherein they – somehow – "log" their achievement of all the identified competences.

The underlying "principle" of such competences is that a person needs to be able to "demonstrate" all of their competences, so as to be able to identify themselves as a such-and-such a professional, who is defined as someone with these competences.

In the relational-therapeutic spirit of Existential Therapies, this framework should not be used as a checklist to decide whether individuals fail or success, as this should be part of a broader relationship between the trainer/supervisor and trainee/supervisee. Such an instrument may facilitate the learning process, but it cannot replace a training institute's authentic commitment. Lecturers and supervisors may assess a trainee's progress with such framework anchors as these, based on multiple information sources about the trainee/supervisee, such as the experience of the trainee/supervisee in the class or in supervision, clinical exercises in the class, client work in recording/transcripts, written case studies, evaluations by clients in interviews, questionnaires or routine outcome monitoring. Trainees/supervisees may also use these anchors to reflect on their progress: for example, by describing examples and evidence for each of the competences, and identifying possible areas of improvement. Most likely, there will not be a perfect "end-point" whereby a therapist becomes an expert in all of these competences, as everyone may always have some areas of improvement and anyway, there is no grading within these competences, whereby one is an 'expert' and another is only 'competent'.

How trainees/supervisees could develop their competences is a topic for a different article, as this may involve many pedagogical aspects, such as learning theory, practicing in class, placement/internships in mental health services, working with diverse populations, essays with reflection and reflexivity, individual and group supervision, and also the experience of (not only) personal therapy, but also the type of therapy that they are going to practice. Given the relative paucity of research on Existential Therapies, it is difficult to say whether any single competences are more important than any others; however, it may be argued that a positive working alliance is an essential foundation of an effective therapeutic process, which may facilitate assessment, phenomenological analysis and explicating existential themes (cf. Norcross & Wampold, 2019).

It may be hypothesized that in a four-year psychotherapy training program, students could be expected to improve at least one lev-

el on average on the competences per year. For example, by the end of year 1, students should have reached Level 2 on average on all (or most) of the competences (possibly Level 3 on relational competences, as research seems to suggest the importance of the working alliance); by the end of year 2, students should have reached Level 3 on average on all competences, Level 4 on relational competences, and nothing on Level 1; by the end of year 3, trainees should have reached Level 4 on average on all competences, Level 5 on relational competences, and nothing on Level 2; by the end of year 4, students should have reached Level 5 on average on all competences and nothing on Level 3. However, these are just suggestions, and more research is needed on this.

This competence framework is based on what existential therapists have described as their practices (bottom-up), as well as on what key authors, handbooks, and treatment manuals have suggested (top-down). Thus, this framework may be interpreted as a comprehensive overview of existential-therapeutic competences. Furthermore, most individual competences have been supported by research suggesting their benefits or effects for clients. However, more research is particularly needed on competences about explicating existential themes and meta-competences. Furthermore, overall, existential therapy manuals, which include most of these competences, have shown to have significant effects on improving the psychological well-being and quality-of-life of clients (Vos, Craig & Cooper, 2015; Vos & Vitali, 2018); therefore, researchers may consider including these competences into their treatment manuals.

This framework may be used by commissioners and service organisations to specify and monitor existential therapists' appropriate competence levels. Although further research is required, this framework may facilitate the identification of the range of competences that a service or team may require to meet the needs of an identified population, and of the training needs and supervision competences of managers. Clinical governance may be facilitated by monitoring, not only the outcomes of psychological therapies, but also of the therapist's competences that will most likely bring benefit to the clients. Professional bodies may also use this framework to establish a minimum level of required competences for the accreditation of training programs and for the registration of individual therapists. Finally, this framework may also help to formulate the standards of training, trade, and professional employment, for example for the European Qualifications Framework and the International Standard Classification of Occupations.

References

BOSS, M. (1963). *Psychoanalysis and Daseinsanalysis*. Basic Books: London.

BRITT, E., BLAMPIED, N. M. & HUDSON, S. M. (2003). Motivational interviewing: A review. *Australian Psychologist*, 38(3), pp. 193-201.

BUBER, M. (2012). *I and Thou*. eBookIt.com.

CAIN, D. J. (2002). *Humanistic psychotherapies: Handbook of research and practice*. Washington, DC: American Psychological Association.

CAMPBELL, L., FOUAD, N., GRUS, C., HATCHER, R., LEAHY, K. & MCCUTCHEON, S. (2013). *A practical guidebook for the competency benchmarks*. Washington, DC: American Psychological Association.

CLARKE, V. & BRAUN, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling and Psychotherapy Research*, 18(2), pp. 107-110.

COHN, H. W. (1997). *Existential thought and therapeutic practice: An introduction to existential psychotherapy.* London: Sage.

COOPER, M. (2015). *Existential psychotherapy and counselling: Contributions to a pluralistic practice*. London: Sage.

COOPER, M. (2016). *Existential Therapies*. London: Sage.

COOPER, M. & DRYDEN, W. (Eds.). (2015). *The Handbook of Pluralistic Counselling and Psychotherapy*. London: Sage.

COOPER, M. & JOSEPH, S. (2016). *Psychological Foundations for Humanistic Psychotherapeutic Practice*. London: Sage.

CORREIA, E. A., COOPER, M., BERDONDINI, L. & CORREIA, K. (2017). Characteristic practices of existential psychotherapy: A worldwide survey of practitioners' perspectives. *The Humanistic Psychologist*, 45(3), pp. 217-230.

CORREIA, E. A., COOPER, M. & BERDONDINI, L. (2014). The Worldwide Distribution & Characteristics of Existential Counsellors & Psychotherapists. *Existential Analysis*, 25(2), pp. 35-50.

DAWSON, D. & MOGHADDAM, N. (2015). *Formulation in Action: Applying psychological theory to clinical practice*. Germany, Walter de Gruyter.

DILTHEY, W. (1895). *Collected Works*. Princeton, N.J.

DU PLOCK, S. (Ed.). (2019). *Case Studies in Existential Psychotherapy and Counselling*. London: Wiley.

EAP, **European Association of Psychotherapy** (2013). *The Core Competencies of a European Psychotherapist.* www.psychotherapy-competency.eu/Documents/Revised_Core_Competencies_Feb_2013.pdf

EDELSTEIN, B. (2014). Frames, Attitudes, and Skills of an Existential-Humanistic Psychotherapist. In: *The Handbook of Humanistic Psychology: Theory, Research, and Practice*: 435-450.

ELLIOTT, R. K. & FREIRE, E. (2010). The effectiveness of person-centered and experiential therapies: A review of the meta-analyses. In: *Person-centered and experiential therapies work: A review of the research on counselling, psychotherapy and related practices*: pp. 1-15.

ELLIOTT, R. K., GREENBERG, L. S., LIETAER, G. & LAMBERT, M. J. (2004) Research on experiential psychotherapies. In: *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change,* (pp. 493-539). New York: John Wiley.

FARBER, E. W. (2010). Humanistic–existential psychotherapy competencies and the supervisory process. *Psychotherapy: Theory, Research, Practice, Training*, 47(1), pp. 28-40.

FARBER, E. W. (2012). Supervising Humanistic-Existential Psychotherapy: Needs, possibilities. *Journal of Contemporary Psychotherapy*, 42(3), pp. 173-182.

FOUAD, N. A., GRUS, C. L., HATCHER, R. L., KASLOW, N. J., HUTCHINGS, P. S., MADSON, M. B. & CROSSMAN, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology*, 3(Suppl. 4): pp. 5-26.

FRETWELL, D., LEWIS, M. V. & DEIJ, A. (2001). *A framework for defining and assessing occupational and training standards in developing countries*. Washington, DC: World Bank Human Development Network Education.

GADAMER, H. G. (2004). *Truth and Method*. USA: Bloomsbury Publishing.

GENDLIN, E. T. (1982). *Focusing*. New York: Bantam.

GOLOVCHANOVA, N., DEZUTTER, J. & VANHOOREN, S. (2020). Meaning profiles and the perception of the working alliance at the start of outpatient person-centered, experiential, and existential psychotherapies. *Journal of Clinical Psychology. [Epub ahead of print]*

HATCHER, R. L. & LASSITER, K. D. (2007). Initial training in professional psychology: The practicum competencies outline. *Training and Education in Professional Psychology*, pp: 49-63.

HEIDEGGER, M. (1997). *Der Satz vom Grund (GA 10)*. Frankfurt am Main: Klostermann.

HOFFMAN, L., DIAS, J. & SOHOLM, H. C. (2012). Existential-humanistic therapy as a model for evidence-based practice. In: *Evidence in support of existential-humanistic psychology: Revitalizing the 'Third Force'. Symposium presented at the 120th annual convention of the American Psychological Association*, Orlando, FL.

HOFFMAN, L., VALLEJOS, L., CLEARE-HOFFMAN, H. P. & RUBIN, S. (2015). Emotion, relationship, and meaning as core existential practice: Evidence-based foundations. *Journal of Contemporary Psychotherapy*, 45(1), pp. 11-20.

HOLZHEY-KUNZ, A. (2014). *Daseinsanalysis*. New York: Free Association Books.

HOPE, R. (2004). *The Ten Essential Shared Capabilities - A Framework for the whole of the Mental Health Workforce*. London: Department of Health.

IACOVOU, S. & WEIXEL-DIXON, K. (2015). *Existential Therapy: 100 key points and techniques*. New York: Routledge.

KASLOW, N. L. (2004). Competencies in Professional Psychology. *American Psychologist*, 59: 774-781.

KASLOW, N. J., GRUS, C. L., CAMPBELL, L. F., FOUAD, N. A., HATCHER, R. L. & RODOLF, E. R. (2009). Competency assessment toolkit for professional psychology. *Training and Education in Professional Psychology*, 3, pp. 27-45.

KENDJELIC, E. M. & EELLS, T. D. (2007). Generic psychotherapy case formulation training improves formulation quality. *Psychotherapy: Theory, Research, Practice, Training*, 44(1), pp. 66-81.

LANGDRIDGE, D. (2012). *Existential Counselling and Psychotherapy*. London: Sage.

LANGLE, A. & HOLZHEY-KUNZ, A. (2008). *Existenzanalyse und Daseinsanalyse*. Vienna: Facultas-WUV.

LAENGLE, S. & WURM, C. (Eds.). (2018). *Living Your Own Life: Existential Analysis in Action*. New York: Routledge.

LANTZ, J. E. & WALSH, J. F. (2007). *Short-term existential intervention in clinical practice*. Chicago: Lyceum.

LEVINAS, E. (1961). *Totalité et Infini*. Den Haag: Nijhoff.

LOEWENTHAL, D. (2018). *Post-existentialism and the psychological therapies: Towards a therapy without foundations*. New York: Routledge.

LUCIA, A. D. & LEPSINGER, R. (1999). *The Art and Science of Competency Models*. San Francisco: Jossey-Bass.

LUKAS, E. (2019). *Meaning-Centred Psychotherapy: Viktor Frankl's Logotherapy in Theory and Practice.* Bamberg: Elisabeth-Lukas-Archiv.

LUKAS, E. (2000). *Logotherapy Textbook. Meaning-Centered Psychotherapy.* London: Liberty.

MARSHALL, M. (2012). *Logotherapy revisited: Review of the tenets of Viktor E. Frankl's logotherapy*. Ottawa: Ottawa Institute of Logotherapy.

MEARNS, D. & COOPER, M. (2017). *Working at Relational Depth in Counselling and Psychotherapy*. London: Sage.

MORAN, D. (2000). *Introduction to Phenomenology*. London: Routledge.

NORCROSS, J. C. & LAMBERT, M. J. (Eds.). (2019). *Psychotherapy Relationships that Work: Volume 1: Evidence-based therapist contributions*. Oxford: Oxford University Press.

OVERHOLSER, J. C. (2011). Collaborative Empiricism, Guided Discovery, and the Socratic Method: Core processes for effective cognitive therapy. *Clinical Psychology: Science and Practice*, 18(1), pp. 62-66.

PAGE, A. C., STRITZKE, W. G. & MCLEAN, N. J. (2008). Toward science-informed supervision of clinical case formulation: A training model and supervision method. *Australian Psychologist*, 43(2), pp. 88-95.

RAYNER, M. & VITALI, D. (2018). Existential Experimentation: Structure and Principles for a Short-Term Psychological Therapy. *Journal of Humanistic Psychology*, 58(2), pp. 194-213.

ROBERTS, M. C., BORDEN, K. A., CHRISTIANSEN, M. D. & LOPEZ, S. J. (2005). Fostering a culture shift: Assessment of competence in the education and careers of professional psychologists. *Professional Psychology: Research and Practice*, 36, pp. 355-361.

RUBIN, N. J., BEBEAU, M., LEIGH, I. W., LICHTENBERG, J. W., NELSON, P. D., PORTNOY, S. & KASLOW, N. J. (2007). The competency movement within psychology: An historical perspective. *Professional Psychology: Research and Practice*, 38, pp. 452-462.

ROTH, A., HILL, A. & PILLING, S. (2009). *The Competences Required to Deliver Effective Humanistic Psychological Therapies.* London: University College.

ROTH, A. D. (2015). Are Competence Frameworks Fit for Practice? Examining the validity of competence frameworks for CBT, psychodynamic, and humanistic therapies. *Psychotherapy Research*, 25(4): 460-472.

RUSSO-NETZER, P., SCHULENBERG, S. E. & BATTHYANY, A. (Eds.). (2016). *Clinical Perspectives on Meaning: Positive and existential psychotherapy*. New York: Springer.

SANGHI, S. (2016). *The Handbook of Competency Mapping: Understanding, designing and implementing competency models in organizations*. India: Sage.

SCHNEIDER, K. J. (2016). Existential-Integrative Therapy: Foundational implications for integrative practice. *Journal of Psychotherapy Integration*, 26(1), pp. 49.

SCHULENBERG, S. E. (2016). *Clarifying and Furthering Existential Psychotherapy*. New York: Springer.

SPINELLI, E. (1994). *Demystifying therapy*. London: Constable.

SPINELLI, E. (1997). *Tales of Un-Knowing: Therapeutic encounters from an existential perspective*. New York: NYU.

SPINELLI, E. (2005). *The Interpreted World: An introduction to phenomenological psychology*. London: Sage.

SPINELLI, E. (2014). *Practising Existential Therapy: The relational world*. London: Sage.

STEVENS, G. W. (2013) A critical review of the science and practice of competency modelling. *Human Resource Development Review*, 12 (1), pp. 86-107.

STRASSER, F. & STRASSER, A. (1997). *Existential Time-Limited Therapy: The wheel of existence.* New York: John Wiley.

THOMAS, J. C. (2010). *Handbook of Clinical Psychology Competencies*. New York: Springer.

VALLEJOS, L. & JOHNSON, Z. (2019). Multicultural Competencies in Humanistic Psychology. *Humanistic Approaches to Multiculturalism and Diversity: Perspectives on Existence and Difference*. New York: Taylor Francis.

VAN DEURZEN, E. & ADAMS, M. (2016). *Skills in Existential Counselling & Psychotherapy*. London: Sage.

VAN DEURZEN, E. & ARNOLD-BAKER, C. (Eds.). (2005). *Existential Perspectives on Human Issues: A handbook for therapeutic practice*. London: Macmillan.

VAN DEURZEN, E. & ARNOLD-BAKER, C. (2018). *Existential Therapy: Distinctive features*. New York: Routledge.

VAN DEURZEN, E., LÄNGLE, A., SCHNEIDER, K. J., TANTAM, D. & DU PLOCK, S. (2019). *The Wiley World Handbook of Existential Therapy*. London: Wiley Blackwell.

VOS, J. (2013). Quantitative Research and Existential Therapies: Hard science versus hard words? *Hermeneutic Circular*, (2), pp. 15-20.

VOS, J. (2015). Meaning and existential givens in the lives of cancer patients: A philosophical perspective on psycho-oncology. *Palliative & Supportive Care*, 13(4), pp. 885-900.

VOS, J. (2016). Working with meaning in life in mental health care: A systematic literature review of the practices and effectiveness of meaning-centred therapies. In: *Clinical Perspectives on Meaning*. Cham: Springer.

VOS, J. (2016a). Working with meaning in life in chronic or life-threatening disease: A review of its relevance and the effectiveness of meaning-centred therapies. In: *Clinical Perspectives on Meaning*. Cham: Springer.

VOS, J. (2017). *Meaning in Life: An evidence-based handbook for practitioners*. London: Macmillan.

VOS, J. (2019). A review of research on existential-phenomenological therapies. In: *The Wiley World Handbook of Existential Therapy*. Wiley Blackwell: London.

VOS, J. (2020). *The Economics of Meaning in Life: From Capitalist Life Syndrome to Meaning-Oriented Economy*. Colorado Springs: University Professors Press.

VOS, J. (2020a). Systematic Pragmatic Phenomenological Analysis (SPPA): Step-wise guidance for mixed methods research. *Under review*.

VOS, J., COOPER, M., CORREIA, E. & CRAIG, M. (2015). Existential Therapies: A Review of Their Scientific Foundations and Efficacy. *Existential Analysis*, 26(1), pp. 20-30.

VOS, J., COOPER, M., CORREIA, E. & CRAIG, M. (2015a). Existential Therapies: A review of scientific studies and their underlying philosophies. *International Journal of Psychotherapy*, 19(1), pp. 47-57.

VOS, J., CRAIG, M. & COOPER, M. (2015). Existential Therapies: A meta-analysis of their effects on psychological outcomes. *Journal of Consulting and Clinical Psychology*, 83(1), pp. 115-125.

VOS, J., ROBERTS, R. & DAVIES, J. (2019). *Mental Health in Crisis*. London: Sage.

VOS, J. & VITALI, D. (2018). The effects of psychological meaning-centered therapies on quality of life and psychological stress: A meta-analysis. *Palliative & Supportive Care*, 16(5), pp. 608-632.

WHIDDETT, S. & HOLLYFORDE, S. (2003) *A practical guide to competencies: how to enhance individual and organisational performance*. London: Chartered Institute of Personnel and Development.

WONG, P. T. (Ed.). (2013). *The Human Quest for Meaning: Theories, research, and applications*. New York: Routledge.

YALOM, I. D. (2020). *Existential Psychotherapy*. UK: Hachette.

YOUNG, C., SZYSZKOWITZ, T., OUDIJK, R., SCHULTESS, P. & STABINGIS, A. (2013). The EAP Project to Establish the Professional Competencies of a European Psychotherapist. *International Journal of Psychotherapy*, 17(2), pp. 40-58.

TABLES AND FIGURES

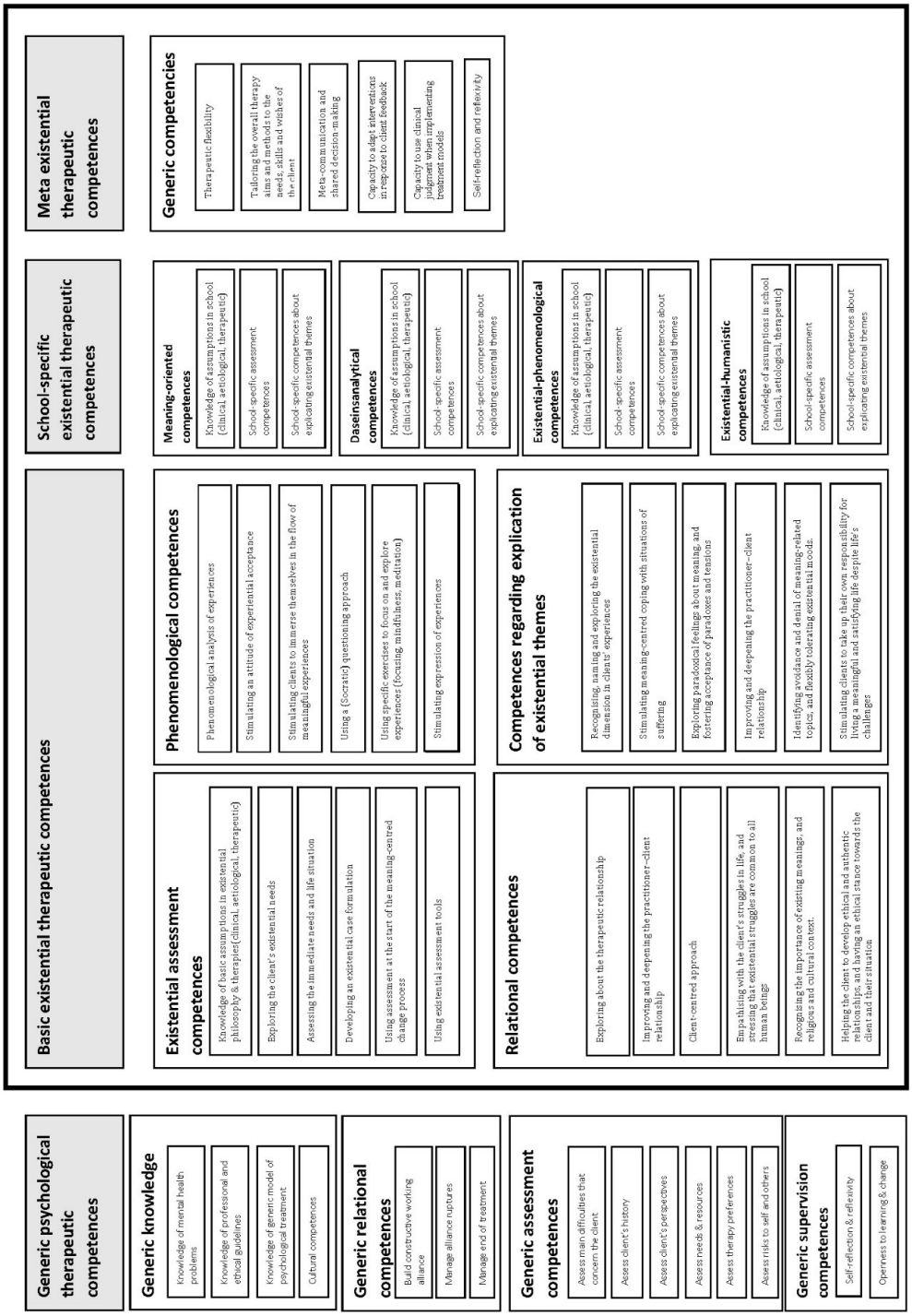

Figure 1. *Visualisation of the existential therapy competences framework*

APPENDICES

Appendix 1. *Definition of Existential Therapy According to the World Confederation for Existential Therapy*

Existential Therapy
World Confederation for Existential Therapy

Preface

In 2014-2016, an international group representing a cross-section of contemporary existential therapists joined together in a cooperative effort to create this broad definition. It was written in the spirit of inclusiveness and diversity that characterizes this unique orientation, toward the goal of arriving at an accessible, succinct, "good enough" working definition of existential therapy. This definition recognises and honours the shared and unifying stance which underpins and informs the various differing ways of understanding and practicing existential therapy today, without doing violence to its inherent spontaneity, flexibility, creativity and mystery. What follows is the current version of an ongoing, continually evolving, collective quest.

1 *What is Existential Therapy?*

Existential therapy is a philosophically informed approach to counseling or psychotherapy. It comprises a richly diverse spectrum of theories and practices. Due partly to its evolving diversity, existential therapy is not easily defined. For instance, some existential therapists do not consider this approach to be a distinct and separate "school" of counseling or psychotherapy, but rather an attitude, orientation or stance towards therapy in general. However, in recent years, existential therapy is increasingly considered by others to be a particular and specific approach unto itself. In either case, it can be said that though difficult to formalize and define, at its heart, existential therapy is a profoundly philosophical approach characterized in practice by an emphasis on relatedness, spontaneity, flexibility, and freedom from rigid doctrine or dogma. Indeed, due to these core qualities, to many existential therapists, the attempt to define it seems contradictory to its very nature.

As with other therapeutic approaches, existential therapy primarily (but not exclusively) concerns itself with people who are suffering and in crisis. Some existential therapists

intervene in ways intended to alleviate or mitigate such distress when possible and assist individuals to contend with life's inevitable challenges in a more meaningful, fulfilling, authentic, and constructive manner. Other existential therapists are less symptom-centered or problem-oriented, and engage their clients in a wide-ranging exploration of existence without presupposing any particular therapeutic goals or outcomes geared toward correcting cognitions and behaviors, mitigating symptoms or remedying deficiencies. Nevertheless, despite their significant theoretical, ideological and practical differences, existential therapists share a particular philosophically-derived worldview which distinguishes them from most other contemporary practitioners.

Existential therapy generally consists of a supportive and collaborative exploration of patients' or clients' lives and experiences. It places primary importance on the nature and quality of the here-and-now therapeutic relationship, as well as on an exploration of the relationships between clients and their contextual lived worlds beyond the consulting room. In keeping with its strong philosophical foundation, existential therapy takes the human condition itself – in all its myriad facets, from tragic to wondrous, horrific to beautiful, material to spiritual – as its central focus. Furthermore, it considers all human experience as intrinsically inseparable from the ground of existence, or "being-in-the-world", in which we each constantly and inescapably participate.

Existential therapy aims to illuminate the way in which each unique person – within certain inevitable limits and constraining factors – comes to choose, create and perpetuate his or her own way of being in the world. In both its theoretical orientation and practical approach, existential therapy emphasizes and honors the perpetually emerging, unfolding, and paradoxical nature of human experience, and brings an unquenchable curiosity to what it truly means to be human. Ultimately, it can be said that existential therapy confronts some of the most fundamental and perennial questions regarding human existence: "Who am I?" "What is my purpose in life?" "Am I free or determined?" "How do I deal with my own mortality?" "Does my existence have any meaning or significance?" "How shall I live my life?"

2 *Why is it called "Existential" Therapy?*

Existential therapy is based on a broad range of insights, values, and principles derived from phenomenological and existential philosophies. These philosophies of existence stress certain "ultimate concerns" – often in dialectical tension with each other – such as freedom of choice, the quest for meaning or purpose, and the problems of evil, isolation, suffering, guilt, anxiety, despair, and death. For existential therapists, "phenomenology" refers to the disciplined philosophical method by which these ultimate concerns or "givens" are addressed, and through which the person's basic experience of being-in-the-world can best be illuminated or revealed, and thus, more accurately understood. This phenomenological method begins by deliberately trying to set aside one's presuppositions so as to be more fully open and receptive to the exploration of another person's subjective reality.

Though there can be many different motivations for individuals choosing to engage in this explorative process, as with most forms of counseling, psychotherapy, or psychological and psychiatric treatment, existential therapy is commonly sought by people in the throes of an existential crisis: some specific circumstance in which we experience our basic sense of survival, security, identity or significance as being threatened. Such existential threats may be of a physical, social, emotional or spiritual nature, and may be directed toward one's self, others, the world in general or the ideas and perceptions we live by. They shock and shake us out of our sense of safety and complacency, forcing us to question and doubt our most deeply held beliefs or values. Because, according to existential therapists, human existence is, by its very nature, continually changing or becoming, we are naturally prone to experiencing such existential challenges or crises across the lifespan. In existential therapy, these disorienting and anxiety provoking periods of crisis are perceived as both a perilous passage and an opportunity for transformation and growth.

3 *How does Existential Therapy work?*

Existential therapists see their practice as a mutual, collaborative, encouraging and explorative dialogue between two struggling human beings – one of whom is seeking assistance from the other who is professionally trained to provide it. Existential therapy places special emphasis on cultivating a caring, honest, supportive, empathic yet challenging relationship between therapist and client, recognizing the vital role of this relationship in the therapeutic process.

In practice, existential therapy explores how clients' here-and-now feelings, thoughts and dynamic interactions within this relationship and with others might illuminate their wider world of past experiences, current events, and future expectations. This respectful, compassionate, supportive yet nonetheless very real encounter – coupled with a phenomenological stance – permits existential therapists to more accurately comprehend and descriptively address the person's way of being in the world. Taking great pains to avoid imposing their own worldview and value system upon clients or patients, existential therapists may seek to disclose and point out certain inconsistencies, contradictions or incongruence in someone's chosen but habitual ways of being. By so doing, some existential therapists will, when necessary, constructively confront a person's sometimes self-defeating or destructive ways of being in the world. Others will deliberately choose to avoid viewing or addressing any experience or expression of the person's being in the world from a perspective that construes it as being positive/negative, constructive/destructive, healthy/unhealthy, etc. In either case, the therapeutic aim is to illuminate, clarify, and place these problems into a broader perspective so as to promote clients' capacity to recognize, accept, and actively exercise their responsibility and freedom: to choose how to be or act differently, if such change is so desired; or, if not, to tolerate, affirm and embrace their chosen ways of being in the world.

To facilitate this potentially liberating process, existential therapy focuses primarily on enhancing the person's awareness of his or her "inner" experiencing, "subjectivity" or

being: the temporal, transitory, vital flux of moment-to-moment thoughts, sensations and feelings. At the same time, existential therapy recognizes the inevitable interplay between past, present and future. In this regard, existential therapists respect the impressive power of the past and the future, and directly address it as it impacts upon the present.

4 What makes Existential Therapy different from other therapies?

In addition to its unique combination of philosophical worldview, phenomenological stance, and core emphasis on both the therapeutic relationship and actual experience, existential therapy is generally less focused on diagnosing psychopathology and providing rapid symptom relief per se than other forms of therapy. Instead, distressing "symptoms" such as anxiety, depression or rage are recognized as potentially meaningful and comprehensible reactions to current circumstances and personal contextual history. As such, existential therapy is primarily concerned with experiencing and exploring these disturbing phenomena in depth: directly grappling with rather than trying to immediately suppress or eradicate them. Consistent with this, existential therapy tends to be more exploratory than specifically or behaviorally goal-oriented. Its principal aim is to clarify, comprehend, describe and explore rather than analyze, explain, treat or "cure" someone's subjective experience of suffering.

5 What techniques or methods do Existential Therapists employ?

Existential therapy does not define itself predominantly on the basis of any particular predetermined technique(s). Indeed, some existential therapists eschew the use of any technical interventions altogether, concerned that such contrived methods may diminish the essential human quality, integrity, and honesty of the therapeutic relationship. However, the one therapeutic practice common to virtually all existential work is the phenomenological method. Here, the therapist endeavors to be as fully present, engaged, and free of expectations as possible during each and every therapeutic encounter by attempting to temporarily put aside all preconceptions regarding the process. The purpose is to gain a clearer contextual in-depth understanding and acceptance of what a certain experience might signify to this specific person at this particular time in his or her life.

Many existential therapists also make use of basic skills like empathic reflection, Socratic questioning, and active listening. Some may also draw on a wide range of techniques derived from other therapies such as psychoanalysis, cognitive-behavioral therapy, person-centered, somatic, and Gestalt therapy. This technical flexibility allows some existential practitioners the freedom to tailor the particular response or intervention to the specific needs of the individual client and the continually evolving therapeutic process. However, whatever methods might or might not be employed in existential therapy, they are typically intentionally chosen to help illuminate the person's being at this particular moment in his or her history.

6 What are the goals of Existential Therapy?

The overall purpose of existential therapy is to allow clients to explore their lived experience honestly, openly and comprehensively. Through this spontaneous, collaborative process of discovery, clients are helped to gain a clearer sense of their experiences and the subjective meanings they may hold. This self-exploration provides individuals with the opportunity to confront and wrestle with profound philosophical, spiritual and existential questions of every kind, as well as with the more mundane challenges of daily living. Fully engaging in this supportive, explorative, challenging process can help clients come to terms with their own existence, and take responsibility for the ways they have chosen to live it. Consequently, it can also encourage them to choose ways of being in the present and future that they, themselves, identify as more deeply satisfying, meaningful and authentic.

7 Who can potentially benefit from Existential Therapy?

An existential approach may be helpful to people contending with a broad range of problems, symptoms or challenges. It can be utilized with a wide variety of clients, ranging from children to senior citizens, couples, families or groups, and in virtually any setting, including clinics, hospitals, private practices, the workplace, organizations, and in the wider social community. Because existential therapy recognizes that we always exist in an inter-relational context with the world, it can be especially useful for working with clients from diverse demographic and cultural backgrounds.

While existential therapy is particularly well-suited to people who are seeking to explore their own philosophical stance toward life, it may, in some cases, be a less appropriate choice for patients in need of rapid remediation of painful, life-threatening or debilitating psychiatric symptoms. However, precisely due to its fundamental focus on a person's entire existence rather than solely on psychopathology and symptoms, existential therapy can nonetheless potentially be an effective approach in addressing even the most severe reactions to devastating psychological, spiritual or existential disruptions or upheavals in their lives, whether in combination with psychiatric medication when needed or on its own.

8 What scientific evidence is there regarding the efficacy of Existential Therapy?

A range of well-controlled studies indicate that certain forms of existential therapy, for certain client groups, can lead to increased well-being and sense of meaning (Vos, Craig & Cooper, 2014). This body of evidence is growing, with new studies showing that Existential Therapies can produce as much improvement as other therapeutic approaches (e.g., Rayner & Vitali, in press). This finding is consistent with decades of scientific research which shows that, overall, all forms of psychotherapy are effective, and that, on average, most therapies are more or less equally helpful (Seligman, 1995; Wampold & Imel, 2015),

with specific client characteristics and preferences determining the best therapeutic approach for any given individual. There is also a good deal of evidence indicating that one of the core qualities associated with existential therapy – a warm, valuing and empathic client or patient-therapist relationship – is predictive of positive therapeutic outcomes (Norcross & Lambert, 2011). Additionally, existential therapy's central emphasis on finding or making meaning has been shown in general to be a significant factor in effective treatment (Wampold & Imel, 2015).

9 *Where can I find out more about Existential Therapy and/or professional training to become an Existential Therapist?*

Until recently, there were few if any formal training programs for existential therapists. In recent years, this situation has changed, with the creation of various training programs in the United States, the United Kingdom, Belgium, Austria, Germany, Switzerland, Italy, Portugal, Russia, Canada, Scandinavia, Israel, Argentina, Mexico, Chile, Peru, Colombia, Brazil, Lithuania, Greece, Australia and many other countries.

A full list of training courses has been compiled by Edgar A. Correia and is available on this website.

Additional References

Norcross, J. C. & Lambert, M. J. (2011). Evidence-based therapy relationships. In: J. C. Norcross (Ed.), *Psychotherapy Relationships that Work: Evidence-based responsiveness* (2nd ed., pp. 3-21). New York: Oxford University.

Rayner, M. & Vitali, D. (in press). Short-term existential psychotherapy in primary care: A quantitative report. *Journal of Humanistic Psychology*. [Spanish translation published as: Rayner, M. y Vitali, D. (2015). Psicoterapia existencial de corto plazo en atención primaria: Un reporte cuantitativo. Revista electrónica Latinoamericana de Psicologia Existencial "Un enfoque comprensivo del ser". N° 11. Octubre.]

Vos, J., Craig, M. & Cooper, M. (2014). Existential Therapies: A meta-analysis of their effects on psychological outcomes. *Journal of Consulting and Clinical Psychology*, 83(1), 115-128. doi: 10.1037/a0037167

Wampold, B. E., & Imel, Z. E. (2015). *The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work* (2nd Ed.). New York: Routledge.

Appendix 2. *Overview of competences with definitions and anchors*

Competence	Definition	Beginner's level (Level 1)	Intermediate level (Level 3)	Advanced level (Level 5)
Generic Competences				
Generic knowledge	Knowledge of mental health problems, work context, professional and ethical guidelines, general psychological model, and cultural competences (see main text for details)	Basic knowledge of central theories and guidelines	In-depth knowledge and application of a variety of theories and guidelines, and ability to apply these in work with clients	Ability to critically reflect on and flexibly apply theories and guidelines, and to join professional discussions and have a unique contribution
Generic relational skills	Ability to build and maintain a constructive therapeutic relationship, repair alliance ruptures and end therapy (see main text for details)	Ability to build and maintain a basic positive working alliance, solve minor relational problems, and emotionally support the client when ending therapy	Ability to use the therapeutic relationship for therapeutic progress, solve complex alliance ruptures, and help the client to sustain the gains of therapy after the end of therapy and to prevent relapse	Ability to work at relational depth to support the assessment, phenomenological analysis and explication of existential themes; ability to repair complex alliance ruptures and to use this to help the client develop self-insight or new skills; help the client to help themselves and continue improvement after the end of therapy
Generic assessment	Ability to do a generic assessment of the main concerns, history, perspectives, needs, resources, motivation for psychological help, discussion of treatment options, and risk assessment (see main text for details)	Ability to do a basic assessment with the help of an assessment guideline without causing iatrogenic damage	Ability to do an in-depth assessment tailored to the client, without iatrogenic damage	Ability to do a complex, in-depth, tailored assessment, which helps the client to develop self-insight and an understanding of their situation

Generic supervision skills	Ability to arrange appropriate supervision, be reflective and open to criticism, willing to learn and to consider and solve gaps in competencies	Ability to arrange appropriate supervision, fundamental openness and self-reflection, dependence on the guidance by the supervisor, and some topics may still be avoided	Ability to arrange appropriate supervision, openness and self-reflection, more active contribution to the supervision sessions, developing self-insight, willingness to open up themselves and explore difficult areas	Ability to arrange appropriate supervision, openness and self-reflection, active role in supervision, discussion and contribution at an equal level with peers, benefitting optimally from supervision by developing self-insight, as reflected in significant improvement in the work with clients
Existential Assessment Skills				
Knowledge of basic assumptions in existential philosophy and psychotherapies	Knowledge of existential philosophers, clinical, aetiological, and therapeutic models in Existential Therapies	Basic knowledge of key existential authors, theories, and models from at least one existential-therapeutic school	In-depth knowledge of a variety of existential theories and models and ability to apply these in work with clients	Ability to critically reflect on and flexibly apply existential theories and models, and to join professional discussions and have a unique contribution
Exploring the client's existential needs & building an existential case formulation	Ability to conduct a non-reductionist assessment and case formulation in existential terms, which is as clear and as brief as possible, holistic, precise, empirically testable, and followed with research-based hypotheses about mechanisms of the aetiology and the treatment	Ability to do a basic assessment with the help of an assessment guideline	Ability to do an in-depth assessment tailored to the client, with the help of existential models	Ability to do a complex, in-depth, tailored assessment, with the help of existential models and research, which helps the client to develop self-insight and a better understanding of their situation

Competence	Definition	Beginner's level (Level 1)	Intermediate level (Level 3)	Advanced level (Level 5)
Assessing the immediate needs and life situation of the client	Ability to recognise, assess and work with the client's wider societal, political, and economic world in which the clients live and which may have direct consequences for their physical daily life situation, personal and existential well-being	Basic knowledge of key problems in the broader societal, political. and economic world of the client	Ability to assess and address key problems in the broader societal, political. and economic world of the client	Ability to help the client to develop self-insight in how their problems and their life situation are embedded in a broader societal, political. and economic world, and how to respond in an authentic and meaningful way to this
Using assessment at the start of the therapeutic change process	Finding a balance between assessing problems and strengths/ resources, preventing iatrogenic damage from a negative-oriented assessment, supporting to develop self-insight and possible solutions	Ability to explore both problems and strengths/resources with the help of an assessment guide-line without creating iatrogenic damage	Ability to do an in-depth tailored assessment of both problems and strengths/resources without creating iatrogenic damage	Ability to do a complex, in-depth, tailored assessment of both problems and strengths/ resources, which helps the client to develop self-insight and a better understanding of their situation
Using existential assessment tools	Using routine outcome monitoring, questionnaires, and other tools in the assessment in a non-reductionist, client-oriented way	Ability to let clients fill in questionnaires and interpret the scores	Ability to explain the scores of the questionnaire to the client, to help them develop self-insight and to guide the aims and methods of therapy	Ability to select a range of tools tailored to the client, to help them develop self-insight, deepen the process of experiencing and explicating existential themes, and help shared decision-making about the goals and methods of therapy

Phenomenological Competences				
Phenomenological analysis of experiences	Knowledge of phenomenological theories, having a generic phenomenological stance towards the client, using specific phenomenological approaches to explore the client's experiences	Knowledge of phenomenological principles; ability to apply a simple phenomenological analysis with the help of a structured guideline; ability to have a basic phenomenological stance towards the client (e.g. bracketing one's assumptions)	Knowledge of multiple phenomenological methods, and Ability to apply these in the exploration of experiences with clients, and Ability to have a phenomenological stance towards the client	In-depth knowledge of phenomenological methods, and Ability to explain these to the client, and use these efficiently in work with clients to help them develop self-insight and explore their experiences at existential depth, and Ability to use the phenomenological methods to deepen the therapeutic relationship
Stimulating an attitude of experiential acceptance	Ability to help clients listen to their experiences instead of suppressing these (experiential acceptance): 'accepting that we experience what we experience, focusing on experiences and trusting these experiences to show possible directions in life. Several practitioners have differentiated helpful from unhelpful experiential attitudes, which either help or block individuals from experiencing meaningful experiences.'	Ability to invite clients to explore their experiences at some depth and to stay with these experiences instead of suppressing or avoiding these experiences	Ability to help clients explore and trust their experiences, tolerate difficult experiences, and identify unhelpful attitudes towards their experiences	Ability to help clients trust their range of experience as a source of self-development and developing more positive attitudes towards their experiences

Competence	Definition	Beginner's level (Level 1)	Intermediate level (Level 3)	Advanced level (Level 5)
Stimulating clients to immerse themselves in the flow of meaningful experiences	Ability to help clients immerse themselves into the flow of experiencing	Ability to identify when clients do not immerse themselves into the flow of experiencing, and possible causes for this (e.g. due to hyper-reflection or hyper-intention)	Ability to help clients develop insight into how they can immerse themselves in the flow of experiencing, and to identify possible causes	Ability to help clients to overcome possible problems preventing them from immersing themselves in the flow of experiencing, and making more conscious decisions and having more control over when they immerse themselves in the flow of experiencing
Phenomenologically exploring hierarchies in the client's experiences	Ability to help clients identify levels/layers/meanings in their experiences, differentiating the more-meaningful from the less-meaningful, and deepen their experiences	Ability to guide clients in their explorations of different levels/ layers/meanings in experiences	Ability to guide clients in identifying what they experience as more-meaningful and what as less-meaningful	Ability to help clients in differentiating what they experience as more-meaningful and what as less-meaningful, and to consciously use this experiential differentiation in the decisions and actions in daily life
Using a (Socratic) questioning approach	Ability to use a relatively non-directive approach, via asking questions, or Socratic Dialogue or another relatively non-directive approach, to support the client's journey of self-exploration	Ability to ask open questions in a non-directive way, and not imposing the therapist's own answers	Ability to use questions in a relatively non-directive and non-imposing way to explore the client's experiences	Ability to use a systematic questioning approach or Socratic Dialogue to help the client explore their experiences, develop self-insight, and explore existential themes

Using specific and non-verbal exercises to focus on and explore experiences	Ability to use a variety of experiential techniques to help clients explore their experiences	Ability to use simple experiential techniques with clear guidance	Ability to select and apply experiential techniques to help the client explore their experiences	Ability to select from a range of possible experiential techniques and flexibly apply and tailor these to the client, to help the client in their exploration of experiences, including more complex, difficult and existential experiences
Stimulating expression of emotions	Ability to help clients actively express and articulate emotions, make sense of experiences that are confusing and distressing and help clients to reflect on and develop emotional meanings	Ability to invite clients to express their experiences	Ability to invite clients to express and deepen their experiences, and name these	Ability to invite clients to express and deepen their experiences, name these, and Ability to reflect on the content and process of the expression and to help clients develop more refined articulation of their experiences
Relational Competences				
Exploring the therapeutic relationship	Ability to shift away from a mere intrapsychic approach to a more inter-subjective approach, including Ability to work with the immediate relationship, conscious and unconscious processes, offering the holding and safety for clients express and explore experiences at existential depth, and using the relationship as a possible source of information about how clients relate to other people in their life in the present or past, and help clients learn new insights and skills in the therapeutic relationship	Ability to have a basic reflection on the therapeutic relationship, and to offer a sense of basic holding and safety	Ability to reflect on conscious and unconscious aspects of the therapeutic relationship, offer holding and safety to the client, explore how the therapeutic relationship may reflect other past and present relationships	Ability to reflect on conscious and unconscious aspects of the therapeutic relationship, offer holding and safety to the client, explore how the therapeutic relationship may reflect other past and present relationships, and using the relationship to explore experiences at existential depth, and learn new insights and skills

Competence	Definition	Beginner's level (Level 1)	Intermediate level (Level 3)	Advanced level (Level 5)
Improving and deepening the practitioner-client relationship	Ability to apply a variety of competences to improve and deepen the therapeutic relationship, including being authentic, genuine, open and trustworthy, and using self-disclosure within boundaries.	Ability to have a basic constructive working relationship, the ability to reflect on the relationship and make basic improvements	Ability to use some skills to improve the relationship and to stimulate depth in the therapeutic relationship	Ability to flexibly use a variety of skills to improve and deepen the relationship, and to work with the client at relational depth
Having a client-centred stance	Ability to stimulate growth through a rigorous focus on the issues and perspectives brought by the client, and following the client instead of imposing their own agenda regarding the aims and methods of the therapy	Ability to be aware of possible imposing of the own agenda onto the client, to bracket their own agenda where possible, and to invite the client to freely share their experiences	Ability to stimulate the client to share their issues and perspectives, to identify the unique issues and perspectives of the client, and not to impose one's own agenda onto the client	Ability to focus on the issues and perspectives that clients bring up and use these to stimulate growth, without imposing the therapist's own agenda
Empathising with the client's struggles in life, and stressing that existential struggles are common to all human beings	Ability to empathising verbally and non-verbally with the client's struggles in life, and stressing that existential struggles are common to all human beings	Ability to verbally express empathy for the client's conscious struggles in life	Ability to verbally express empathy for the client's conscious and unconscious struggles in life, and stressing that existential struggles are common to all human beings	Ability to verbally and non-verbally express empathy for the client's conscious and unconscious struggles in life, stressing that existential struggles are common to all human beings, and using this empathy and normalisation to help the client develop self-insight

Recognising the importance of existing meanings, religious and cultural context	Ability to recognise, respect, underline the importance, and work with the client's existing meanings, religious and cultural context via diverse techniques, such as unconditional acceptance, unconditional positive regard, non-possessive warmth, prizing, respecting, affirming, and valuing the client's humanity	Ability to recognise and respect the client's existing meanings, religious and cultural context in some ways, without imposing one's perspective	Ability to recognise, respect and underline the importance of the client's existing meanings, religious and cultural context in various ways, without imposing one's perspective	Ability to recognise, respect and underline the importance of the client's existing meanings, religious and cultural context in various ways, and using these flexibly and respectful in work with the client, without imposing one's perspective
Helping the client to develop ethical and authentic relationships and having an ethical stance towards the client and their situation	Ability to help clients to develop ethical and authentic relationships, and having an ethical stance towards the client	Ability to having an ethical stance towards the client	Ability to having an ethical stance towards the client, and addressing ethical issues in the therapeutic relationship and in the relationships that the client may have towards oneself, others and the world in general	Ability to having an ethical stance towards the client, and helping them to develop ethical and authentic relationships with themselves, others and the world in general
Competences about Explicating Existential Themes				
Recognising, naming, and exploring the existential dimension in clients' experiences	Ability to recognise, name, and explore the existential dimension in clients' stories, moods, behaviours, and unspoken experiences, via a variety of approaches such as questioning or existential-experiential exercises	Ability to recognise, and name in clients' stories, moods and behaviours, via some approaches such as questioning	Ability to recognise, name, and explore the existential dimension in clients' stories, moods, behaviours, and unspoken experiences, via several approaches such as questioning	Ability to recognise, name, and explore the existential dimension in clients' stories, moods, behaviours, and unspoken experiences at a deep level, via a variety of approaches such as questioning or existential-experiential exercises

Competence	Definition	Beginner's level (Level 1)	Intermediate level (Level 3)	Advanced level (Level 5)
Stimulating meaning-centred coping with situations of suffering	Ability to stimulate meaning-centred coping with situations of suffering, such as identifying unrealistic, ineffective, and counterproductive coping styles and expectations, helping clients to accept what they cannot change and changing what they can, and to transcend suffering by focusing on meanings in life	Ability to identify unrealistic, ineffective, and counterproductive coping styles and expectations, helping clients to accept what they cannot change and changing what they can	Ability to identify unrealistic, ineffective, and counterproductive coping styles and expectations, helping clients to accept what they cannot change and changing what they can, and to transcend suffering by focusing on what clients may experience as meaningful in the situation	Ability to identify unrealistic, ineffective, and counterproductive coping styles and expectations, helping clients to accept what they cannot change and changing what they can, to transcend suffering by focusing on meanings in life, and helping to transcend tragedy and grow
Exploring paradoxical feelings about meaning, and fostering tolerance of paradoxes	Ability to recognise, name, explore and help to tolerate paradoxes, ambiguities and tensions in the client's stories, moods, behaviour, and unspoken parts of their experiences, instead of giving black-or-white solutions to life's ailments	Ability to recognise, name and explore paradoxes, ambiguities and tensions in the client's stories, moods and behaviour	Ability to recognise, name, explore and help to tolerate paradoxes, ambiguities and tensions in the client's stories, moods, behaviour and unspoken parts of their experiences, instead of giving black-or-white solutions to life's ailments	Ability to recognise, name, explore and help to tolerate a wide range of complex and subtle paradoxes, ambiguities and tensions in the client's stories, moods, behaviour, and unspoken parts of their experiences, instead of giving black-or-white solutions to life's ailments, and using the paradoxes for developing self-insight and development of new skills

Identifying avoidance and denial of existential topics, and flexibly tolerating existential moods	Ability to identify existential moods, avoidance, and denial of existential topics, differentiating when avoidance/denial is beneficial and when not, and helping clients to tolerate existential moods and use these moods for self-development	Ability to identify existential moods, avoidance and denial of existential topics, differentiating when avoidance/denial is beneficial and when not	Ability to identify existential moods, avoidance and denial of existential topics, differentiating when avoidance/denial is beneficial and when not, and helping clients to tolerate existential moods	Ability to identify existential moods, avoidance, and denial of existential topics, differentiating when avoidance/denial is beneficial and when not, and helping clients to tolerate existential moods and use these moods for self-development
Stimulating clients to take up their responsibility for living a meaningful life	Ability to stimulate clients to take up their responsibility for living a meaningful life via a variety of skills, such as preventing dependency in the therapeutic relationship, or preventing structural denial of life's givens.	Ability to prevent that clients become totally dependent on the therapy	The ability to stimulate clients to take up their responsibility for their development in therapy	The ability to stimulate clients to take up their responsibility for living a meaningful life via a variety of skills, such as preventing dependency in the therapeutic relationship, or preventing structural denial of life's givens
School-specific Existential Competences				
Knowledge of assumptions in school (clinical, aetiological, therapeutic)	Knowledge of assumptions in school (clinical, aetiological, therapeutic)	Basic knowledge of assumptions in school (clinical, aetiological, therapeutic)	Intermediate knowledge of assumptions in school (clinical, aetiological, therapeutic)	Expert knowledge of assumptions in school (clinical, aetiological, therapeutic)
School-specific assessment competences	School-specific assessment competences	Basic school-specific assessment competences	Intermediate school-specific assessment competences	Expert school-specific assessment competences
School-specific competences about explicating existential themes	School-specific competences about explicating existential themes	Basic school-specific competences about explicating existential themes	Intermediate school-specific competences about explicating existential themes	Intermediate school-specific competences about explicating existential themes

Competence	Definition	Beginner's level (Level 1)	Intermediate level (Level 3)	Advanced level (Level 5)
Generic competences				
Therapeutic flexibility	Ability to respond to the individual needs of a client at a given moment in time, via a range of methods, approaches and complex interpersonal skills, under the guidance of very sophisticated mental activities	Ability to identify the overall needs of clients, and some specific needs in specific situations, and address these via several methods	Ability to respond to the individual needs of a client at a given moment in time, via a range of methods, approaches and complex interpersonal skills	Ability to respond to the individual needs of a client at a given moment in time, via a range of methods, approaches and complex interpersonal skills, under the guidance of very sophisticated mental activities
Tailoring the overall therapy aims and methods to the needs, skills and wishes of the client	Ability to tailor the aims and methods of the therapy to the specific needs, skills and wishes of the client	Ability to invite the client to share their needs, skills and wishes, and tailoring the aims and methods of the therapy to some extent	Ability to tailor the aims and methods of the therapy to the specific needs, skills and wishes of the client	Ability to tailor the aims and methods of the therapy to the specific needs, skills and wishes of the client, and staying flexibly focused on these aims and methods and continuously check whether these need to be adjusted due to changing needs, skills and wishes of the client
Meta-communication and shared decision-making	Ability to engage in meta-communication, share decision-making about the overall therapy aims and methods and specific sessions and interventions	Ability to give information and discuss the overall aims and methods of the therapy and ask the client for input for this and create some basic tailoring of these aims and methods	Ability to engage in meta-communication about several aspects in the therapy, share decision-making about the overall therapy aims and methods	Ability to engage in meta-communication, share decision-making about the overall therapy aims and methods and specific sessions and interventions

Capacity to adapt interventions in response to client feedback	Ability to adapt interventions in response to client feedback	Ability to ask for client feedback and use this to a limited extent	Ability to ask for client feedback and use this to change the overall aims and methods of the therapy	Ability to adapt the overall therapy aims and methods, and individual interventions in sessions in response to client feedback
Capacity to use clinical judgment when implementing treatment models	Ability to use clinical judgment when implementing treatment models, by balancing adherence to the existential-therapy model, relational issues and client's needs	Ability to adhere to the existential-therapy model, while addressing some of the client's needs	Ability to use clinical reasoning when implementing and adhering to the existential-therapy model, and balance this to some extent with relational issues and client's needs	Ability to use clinical judgment when implementing treatment models, by balancing adherence to the existential-therapy model, relational issues and client's needs
Self-reflection and reflexivity	Ability to systematically self-reflect and be systematically reflexive regarding the roles and positions of the therapist and the client in the therapy setting and the broader institutional/societal/political/global context, including the mental health care system and the wider economy and politics	Basic ability to self-reflect and be reflexive regarding the therapy sessions	Ability to self-reflect and be reflexive regarding the roles and positions of the therapist and the client in the therapy setting	Ability to systematically self-reflect and be systematically reflexive regarding the roles and positions of the therapist and the client in the therapy setting and in the broader institutional/societal/political/global context, including the mental health care system and the wider economy and politics

NB: Level 2 can be described as 'beginner's level, on the way to intermediate level', and Level 4 can be described as 'intermediate level, on the way to advanced level'

A Pragmatic Framework for the Supervision of Psychotherapy Trainees: Part 1: Directive Guidance

James C. Overholser

Abstract: The supervision of psychotherapeutic practice for trainees is vital for the future of the field. There are two primary goals of such supervision: to protect the well-being of the trainee's clients and to enhance the professional development of the trainee. The present manuscript confronts the core supervisory strategy of directive guidance used to educate the trainee and to ensure the quality of care that is provided to each of the trainee's clients. A psychotherapy supervisor relies on proper training, advanced degree, and professional experience to establish baseline credibility as a supervisor. When supervisors have established an adequate degree of clinical expertise, trainees are likely to accept their guidance and improve their work in therapy. However, without first establishing credibility as a competent psychotherapist who has remained active in the field, the directive guidance may be disregarded by trainees who are beyond the initial stages of training. Most supervisory meetings focus on recent sessions, including a review of clinical documentation and session recordings. Especially when working with novice or trainee therapists, supervisors may take a fairly directive role, teaching basic skills and offering direct advice for how to proceed with therapy. A directive approach to supervision relies on several focused training activities, including brief lectures, assigned readings, role-played simulations and occasional co-led therapy sessions. This paper (the first of a series of 4) explores the advantages and disadvantages of such a directive approach to supervision.

Key Words: supervision, psychotherapy, developmental models

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Psychotherapy is an important service that remains helpful to many people struggling with cognitive or emotional disorders. Many clients gain long-lasting benefit from their participation in psychotherapy sessions, especially when conducted by a skilled therapist. However, the field of psychotherapy requires proper training, monitoring, and supervision of novice therapists in order to enhance the future of the field.

There are at least two primary goals in the supervision of the clinical practice of psychotherapy trainees (Overholser, 2004). Clinical supervisors accept responsibilities for protecting client welfare and enhancing trainee development. First, supervision aims to protect the client and to ensure trainee competence in the services that are being provided. Psychotherapists need to respect the limits of their competence. This includes limiting their work to specific strategies for which they have adequate training and experience and not extending into areas beyond the scope of their competence. The supervisor accepts the professional and legal responsibility for the work that is performed by the trainee (Mitchels & Bond, 2010; Recupero & Rainey, 2007. This legal responsibility becomes relevant in cases of misdiagnosis, improper treatment, and situations where a client has gone on to harm self or others. Thus, even with advanced trainees, it remains important for the supervisor to play an active in the clinical services and for the supervisor to remain informed about all aspects of each client's care.

The second basic goal of supervision involves promoting growth in the trainee. The supervisor focuses on the development of clinical skills, including clinical assessment, psychiatric diagnosis, therapeutic relationship, case conceptualization, and an appreciation for psychotherapy process. Furthermore, the supervisor tries to enhance the trainee's professional development, usually including accurate self-awareness and critical self-evaluation. Especially during the early years of training, novice therapists prefer clear and specific instructions regarding their actions as a therapist (Jacobsen & Tanggaard, 2009).

A mixture of complex models of supervision have been proposed (Watkins *et al*., 2015; Watkins, 2016, 2018; Westerfield, 2009). These complex models provide many interesting theories and heuristics that could advance the research foundation underlying the supervisory process. Some models (e.g., Watkins, 2018) explore supervision in terms of input, processes, and output variables. Other models (e.g., Stoltenberg, 1997; Stoltenberg *et al*., 2014) focus on adapting to the developmental stages of the trainee. Others (e.g., Pearson, 2006) explore the various roles adopted by clinical supervisors, include that of teacher, counselor, and consultant. These models of supervision often rely on the author's experience as a supervisor (e.g., Watkins, 2016). However, because of the abstract nature of these recommendations, they appear difficult to translate into the praxis of the average supervisory meetings. In contrast, most research studies on psychotherapy supervision have been limited to surveys collected from either trainees or clinical supervisors. Research articles usually rely on qualitative studies with small samples of fewer than a dozen trainees (e.g., Hill *et al*., 2007; Jacobsen & Tanggaard, 2009; Maruniakova & Rihacek, 2018; Salter & Rhodes, 2018; Theriault, Gazzola & Richardson, 2009; Truell, 2001) occasionally interviewing a small group of both supervisors and trainees from the same training program (e.g., Henderson, Cawyer & Watkins, 1999). Only a handful of research reports have administered standardized measures with established psychometric properties to a large sample of trainees (e.g., Rousmaniere & Ellis, 2013) or both trainees and supervisors (DePue, Glenn, Lambie, & Gonzalez, 2020). Unfortunately,

there is no accepted standard for what constitutes the "best practice" in clinical supervision (Simpson-Southward, Waller & Hardy, 2017). Some of these surveys reveal useful information in a straight-forward manner. For example, a useful survey of 142 advanced graduate students enrolled in a graduate training program in either clinical psychology or counseling psychology examined views of their best and worst experiences in clinical supervision. The best supervisory experiences included: feedback that was direct and straightforward; practical skills being taught; praise and encouragement provided frequently; and mistakes that were used as opportunities to learn. The expertise and skill of the supervisor was found to be the single most important factor in discriminating the best from the worst supervisory experiences (Allen *et al.*, 1986).

Because there is no established standard for what constitutes the optimal type of supervision (Simpson-Southward *et al.*, 2017), survey results have been used to define key terms such as "best" supervision (Allen *et al.*, 1986; Anderson, Schlossberg, & Rigazio-DiGilio, 2000), "ideal" supervision (Gandolfo & Brown, 1987), and "effective" supervision (Henderson, Cawyer, & Watkins, 1999). However, recommended guidelines for supervision (Association of State and Provincial Psychology Board, 2015) and a comprehensive plan for the best practices for clinical supervision have been described (Borders *et al.*, 2014). Unfortunately, most supervision meetings rely strictly on a discussion of the recent sessions, while infrequently using session recordings, role-played interactions, or direct observation of the trainee in session (Weck *et al.*, 2017). In an attempt to understand which strategies are seen as most helpful, a survey of 102 graduate students currently completing their predoctoral internship (Gandolfo & Brown, 1987) explored trainee views about their actual experiences in supervision as compared to the view of the ideal supervisory experience. Results revealed a mixture of discrepancies whereby the interns preferred several components that were deemed to be present, but insufficient in the ongoing supervision. In essence, these interns reported a desire for their supervisor to focus on facilitating their skill in clinical problem solving, and providing more frequent direct guidance with therapy strategies.

The present paper presents a pragmatic framework that might be easy to adapt to most supervisory sessions (see Figure 1 – at end). The framework includes recommendations derived from more than 30 years of supervision, working with 58 trainees for an average of 12 months (range 6-48 months). The broader framework addresses issues related to directive guidance, a supportive supervisory alliance, individual customization, and Socratic exploration. The present paper explores in detail several ideas and plans related to directive strategies in clinical supervision. Many of the published articles that present models of supervision aim to enhance the theory and research pertaining to psychotherapy training. These models help to stimulate ideas for future research. However, because of their complex structure and abstract nature, most of these models fail to enhance the actual practice of psychotherapy supervision (Storm *et al.*, 2001). The present paper aims to describe strategies and techniques that help to guide supervisors in the actual praxis of supervision.

Supervisor Expertise and Credibility

Most trainees can benefit from the advice offered by a skilled supervisor. However, in order for the advice and guidance from a supervisor to be credible and respected by the trainee, the supervisor needs: **(a)** an advanced degree; **(b)** a license to practice; and **(c)** experience in the field (e.g., Association for Counselor Ed-

ucation & Supervision, 2011; Association of State & Provincial Psychology Boards, 2015). Without the proper background, training, and experience in the field of psychotherapy, either the supervisor's advice may be improper, or the trainee may fail to respect the supervisor's guidance. Credibility relies on credentials. In order to be a trustworthy expert in psychotherapy, the supervisor should possess the proper credentials.

Academic Credentials

Training to become a competent therapist includes a broad spectrum of graduate courses and supervised clinical experience. In most situations, the supervisor needs an advanced degree in the field of psychology, counseling, psychiatry or social work. Graduate coursework can cover important issues related to psychological assessment, psychiatric diagnosis, and a range of psychological treatments. The courses often focus heavily on the theories and research that explains mental illness and its treatment. To function effectively as a supervisor of psychological treatments, a supervisor should possess an advanced degree in a relevant field of mental health, including clinical psychology, counseling psychology, psychiatry, social work, and a few other related fields.

Clinical Training

In addition to an advanced degree, a psychotherapy supervisor should have prior clinical training that included a mixture of didactic coursework integrated with supervised clinical experience conducting the same services which will be provided by the trainee. The clinical training develops and ensures an acceptable level of professional competence in the applied clinical skills. Further, the supervisory experience helps the young professional to understand and appreciate the role of supervision as central to their own professional background.

Accumulated Years of Clinical Experience

In order to function effectively as a qualified teacher or an expert in psychotherapy, the supervisor must establish their professional credibility. Because of the complex nature of mental illness and its treatment, it is recommended that supervisors remain active in the direct provision of psychotherapy sessions in order to accumulate years of experience and continue to refine their skills as a therapist. A survey of 114 doctoral level counselor educators (Ray *et al.*, 2016) found that their own teaching and supervision had been strongly influenced by their own clinical practice, improving the real-world applicability of their educational style. Furthermore, research on various types of professional expertise has found that the person needs between 5 years (Rassafiani *et al.*, 2008) and 15 years (Skovholt *et al.*, 1997) of regular practice in order to refine the skills expected of an expert. Research on the development of expert level skills recommends a minimum of 10 years of practice to reach a consistently sophisticated level of performance (Ericsson *et al.*, 1993). However, expertise in psychotherapy is a complex term (Hill *et al.*, 2017) and may derive more from observed effectiveness with difficult clients than anything related to background credentials or training experiences (Ronnestad, 2016). Thus, it can be helpful for a psychotherapy supervisor to accumulate years of experience providing the services they plan to supervise, and gain experience with a range of clients, including some difficult cases.

Ongoing Involvement in Clinical Activity

It is important for supervisors to remain active in their professional field and in the services relevant to those in which their trainees are working. In addition to the years of accumulated clinical experience, a qualified super-

visor should remain active with the ongoing provision of clinical services to ensure their training and skills do not erode through disuse. In order to appreciate the subtleties of clinical practice, the supervisor should remain active as a front-lines therapist with an open caseload of psychotherapy clients (Overholser, 2019). Ongoing clinical practice usually provides the best grounding for the realities of clinical practice, creating insight into real world applications of abstract theories. By drawing upon the supervisor's own clinical experience, the supervisor can provide useful information to share with trainees (Golia, 2015). In a survey of 488 students enrolled in a graduate training program for social work (Nedegaard, 2014), results showed that when faculty remained active in clinical work, they were significantly better at teaching clinical skills and relating their course material to real world clinical situations. It has been recommended that members of the teaching faculty should be expected to remain active in the practice of their field, including psychology (Overholser, 2019), medicine (Dowie, 2000), law (Cohen, 2018, Zimmerman, 2013) and social work (Golia, 2015; Johnson & Munch, 2010). Unfortunately, a large portion of clinical psychology faculty members have completely discontinued their involvement with clinical services (Himelein & Putnam, 2001).

In summary, the psychotherapy supervisor should be a well-trained and licensed psychologist who remains informed about recent developments in the field. Supervisors should integrate the science and practice of psychology (Overholser, 2010b). The scientist-practitioner model can be useful for supervisors and trainees alike. In addition, it seems important for the directive supervisor to have accrued a substantial number of clinical hours to qualify as an expert in the field (Ericsson *et al.*, 1993; Overholser, 2010a). Finally, the psychotherapy supervisor should remain active in clinical services, personally continuing to work as a psychotherapist.

Supervisory Meetings

Psychotherapy supervisors often provide direct advice and specific guidance for how to approach a specific client. Some have recommended that graduate training should rely on a heavy focus on research to the relative neglect of psychotherapy (McFall, 2006). Furthermore, some types of supervision are highly structured and heavily focused on didactic training (Pretorious, 2006). These regimented programs are often well suited for training academic scholars, but they can also fall short in preparing psychologists to remain active in the practice of psychotherapy.

In order to monitor the quality of clinical services that are provided by a trainee, the supervisor may need to closely monitor the services provided by the trainee. Supervision rarely includes direct observation of the trainee and instead relies heavily on the trainee's report of the topics discussed in each session (Johnson, 2019). Many novice trainees need and respect detailed instruction about effective strategies for treatment. Supervisors usually review progress notes, testing materials, and audio or video recordings of recent sessions. Then, the supervisor can provide informed guidance for how to proceed in therapy. These instructional strategies can include brief lectures, assigned readings, role-payed simulations, and co-led therapy sessions.

The practical matters of clinical supervision usually involve weekly meetings between the supervisor and the trainee. Supervision typically revolves around scheduled meetings, a discussion of recent sessions, a review of session recordings and an approval of clinical documentation. Most trainees need frequent and direct feedback about their performance in session (Friedberg, Gorman, & Beidel, 2009). A

didactic approach to supervision helps to convey knowledge and procedures via lectures, readings, discussions, review of session tapes, role-played simulations, and co-led sessions (Friedberg & Brelsford, 2013). A thoughtful review of their own sessions can help trainees to learn about their own style and improve their work as a clinician (Chow *et al.*, 2015).

A review of any audiotaped recordings, or session notes, provides a useful look back, examining the strengths and weaknesses of what had been said in the most recent session. Reviewing videotapes provides more information than audiotapes, and both are more effective than a simple review of session notes (Binder *et al.*, 1993). Although a review of videotaped sessions can be used to ensure the trainee is providing an acceptable standard of care, when reviewing videotapes, it is useful to take into account the developmental level of the trainee (Huhra *et al.*, 2008). A supportive bond with the supervisor can lessen the trainee's anxiety about being recorded (Topor *et al.*, 2017). In addition, it can be useful to ask trainees to view their own videotaped sessions in order to help them overcome their anxiety about being observed and evaluated (Hurha *et al.*, 2008). The use of video recordings allows access to the nonverbal communication that occurs during most therapy sessions (Haggerty & Hilsenroth. 2011). Without session recordings, the supervisor's ability to monitor the quality of therapy is limited to the trainee's report of topics discussed (Weck *et al.*, 2017). There are considerable ethical issues in recording psychotherapy sessions and trainees need to be well-versed – and well supervised – in these ethical issues. The presence of a recording device can be used to introduce the topic of supervision and explain how the recording will be used in supervision (Speer & Hutchby, 2003) and proper informed consent is important for explaining the procedures to clients (Butler, 2002). Thankfully, recording devices do not disrupt the flow of most sessions, and the recording devices are usually forgotten or ignored by clients (Brown, Moller, & Ramsey-Wade, 2013). Nonetheless, it is important to request informed consent prior to recording (Brown *et al.*, 2013), and it can be useful to explain to clients how the recordings will be used, stored, and erased in order to protect their trust in the privacy of therapy discussions (Funkenstein *et al.*, 2014).

Directive supervision often helps trainees to develop specific competencies (Kaslow, 2012), usually aligned with evidence-based practice and the use of published treatment protocols. The supervisor may provide specific instructions to help the trainee learn specific, focused interventions such as relaxation training, or assertiveness training. The direct advice may begin with a focus on evidence-based practice and established treatment protocols. As part of this training process, it is useful to provide frequent feedback about a trainee's performance (Cummings *et al.*, 2015; Goodyear, 2014). Supervisors can provide detailed feedback in manageable amounts so as to avoid overwhelming the trainee (Borders, 2014). Furthermore, trainees can use various published resources to understand background theory and research related to different styles of therapy. Thus, these supervisory meetings often include traditional teaching strategies, such as assigned readings, brief lectures, role-played interactions, and co-led therapy sessions.

Educational Training Activities

When using a directive approach to supervision, there are four main training activities that are used to guide the trainee. The directive supervision may rely on brief lectures, assigned readings, role-played simulations, and co-led therapy sessions. Each of these educa-

tional training opportunities provides new information that can help to instruct the trainee in useful therapy strategies. With support and guidance, the trainee can use the specific recommendations for revising and improving their approach to therapy. A survey of 357 licensed psychologists in the United Kingdom (Nel, Pezzolesi, & Stott, 2012) revealed that all practitioners reported learning the most from conducting therapy sessions and almost all respondents (97%) found it useful to observe others conduct therapy sessions. Nonetheless, other training resources were rated as important or very important, including lectures (78%), role-played interactions (75%), and attending seminars (74%).

Brief Lectures

The majority of graduate training is based around classroom lectures. As part of the directive style, the supervisor sometimes acts like a teacher, explaining theoretical ideas or recent research studies that underlie effective psychotherapy. Supervisors sometimes provide information to their trainees in the form of brief lectures, explaining specific assessment tools, clarifying differential diagnosis, or describing a different treatment approach. These educational discussions can provide the trainee with information that directly applies to the trainee's current clinical dilemma. The supervisory meetings tend to focus on teaching basic strategies for assessment and therapy. When serving as a clinical teacher, the supervisor helps a novice to learn background information and specific skills that related to effective psychotherapy. Any lecture should be kept brief, and clearly focused on the specific situation that has arisen in recent therapy sessions. It is important to differentiate abstract knowledge and theory from practical reasoning skills needed for clinical practice (Dowie, 2000; Wears, 2004). In fact, several authors (Cohen, 2018; Zimmerman, 2013) have strongly recommended that law school professors should remain active in the practice of law in order to ensure their lectures remain relevant to the real issues that arise during psychotherapy sessions.

Assigned Readings

There are a wide variety of published resources that can help to guide the trainee to a more comprehensive understanding or mental illness and its treatment. However, efforts to quantify professional competence (Sharpless & Barber, 2009) and most graduate training programs Klepac *et al.*, 2012; Johnson & Munch, 2010) seem to overemphasize the value of coursework, empirical knowledge, and the scientific foundation for applied clinical psychology. Many expert recommendations for graduate training overemphasize the importance of theory and research (e.g., Baker, McFall & Shoham, 2008; Baucom & Boeding, 2013; Binder, 1993; McFall, 2006) while largely neglecting the importance of praxis, the actual practical skills needed to deliver psychotherapy in a competent manner (Bearman *et al.*, 2013). Furthermore, good clinical skills involve dealing with many complex situations that are more complex than the neat portrayals displayed in books and training videos (Friedberg, Gorman, & Beidel, 2009). It is important to differentiate between the knowledge that underlies psychological treatments and the life skills that drive the practical application of psychological theory (Smythe *et al.*, 2009). A small research project showed that when trainees attended a workshop and read a treatment manual, the training results in significant increases in trainee confidence but did not produce any significant improvement in their therapy skill (Beidas *et al.*, 2009). Thus, an overreliance on treatment manuals can hinder the development of therapeutic relationship skills (Vakoch & Strupp, 2000). It is essential for clinical training to focus on the cultivation of basic relationship skills that underlie psychotherapy (Binder *et al.*, 1993), but

these skills cannot be learned from readings or lectures. Information that is obtained from published sources (i.e., "book knowledge") can appear simpler than reality when compared with the complex situations that often arise in therapy sessions (Gazzola *et al.*, 2013). Thus, an overreliance on treatment manuals can expand the gap between research and clinical practice (Pagano, Kyle & Johnson, 2017).

Role-played Simulations

Some supervisory meetings include a role-played interaction that simulates the type of discussion held between the trainee and one of their clients. Role-played simulations often look to the future, trying to anticipate future situations that might challenge the trainee in the hopes of anticipating and preparing for what could be said if these issues are discussed in an upcoming session. Usually, these role-played simulations involve the supervisor enacting the role of the client, thereby allowing the trainee to respond as he or she would in an upcoming therapy session. These are usually brief interactions, provide useful feedback (Nikendei *et al.*, 2019), and allow the trainee time to process their actions and revise their therapy style. Role-played interactions can be used to help the trainee rehearse specific therapy skills (Bearman *et al.*, 2013). At some universities, access to a cooperative theater department can be used to enlist drama students to enact the role of mental health clients (Davis *et al.*, 2013). Role-played simulations allow the trainees opportunities to experiment with different therapeutic responses in a safe setting (Folkes-Skinner *et al.*, 2010). The supervisor can provide direct and immediate feedback, with opportunities to try it again using slightly different responses. Role-played simulations help the trainees to develop specific skills, and refine their skills through feedback and repetition (Chow *et al.*, 2015). Supervision that includes role-played simulations and opportunities to model effective therapy skills is more effective than simple discussions (Bearman *et al.*, 2013).

Co-led Therapy Sessions

Co-led therapy sessions can be a vivid way of teaching psychotherapy skills to a novice or an advanced trainee. Co-led therapy sessions allow for "live" supervision and opportunities for the supervisor to have a direct influence on the content and direction of therapy sessions (Shragay & Hoffman, 2015). However, the practicalities of co-led therapy sessions can make it a challenge to implement. It can be difficult to match the schedules of two professionals with the client, and it becomes less cost efficient to assign two therapists to a single client (Golia, 2015). Thus, co-led sessions seem more common when conducting group therapy or family sessions, where it is more common and seems essential to have two group leaders. Co-leadership is a desirable strategy when teaching group therapy skills (Luke & Hackney, 2007). Trainees can learn quite a bit about psychotherapy process by observing their supervisor conduct a psychotherapy session. Critical issues in the therapy plans can be discussed in supervision meetings between therapy sessions (Gafni & Hoffman, 1991). Co-led therapy sessions allow the trainee to observe a skilled role model (Bearman *et al.*, 2013). Based on a survey that was completed by 357 clinical psychologists in the United Kingdom (Nel *et al.*, 2012), Results showed that most psychologists learned most by conducting therapy sessions or observing others lead therapy sessions. The more academic types of preparation: e.g., (academic essays, didactic lectures) played a less important role in the training of most clinical psychologists. By leading therapy sessions with a trainee, the supervisor can serve as an effective role model for effective communication (Clark, Hinton & Grames, 2016) and for establishing a genuine

relationship with clients (Falke *et al.*, 2015). However, the presence of the supervisor can elevate the trainee's concern about their own competence (Okech & Kline, 2005) and may reduce the trainee's willingness to take the lead in family therapy sessions (Falke *et al.*, 2015).

As can be seen, a mixture of strategies can be used to help guide trainees as they begin working as psychotherapists. Supervision meetings can extend beyond a simple exchange of words so the supervisor is not limited to the trainee's description of therapy sessions. By using a mixture of strategies, directive guidance approaches can ensure the two goals of supervision, protecting the welfare of clients and enhancing the professional development of the trainee.

Discussion

Becoming skilled in psychotherapy supervision can be a long and convoluted process (Gazzola *et al.*, 2013; Goodyear, 2014). However, clinical supervision is an important and rewarding process. An important early step in training the next generation of psychotherapists involve directive guidance to help begin the journey while ensuring adequate care of all clients. Structured training with explicit explanations can be especially important with inexperienced trainees at the novice stage (Stoltenberg, 1997), although some authors have disagreed, arguing that inexperienced trainees prefer supportive meetings instead of semi-formal lectures (Reichert & Skjerve, 2000).

Direct guidance can help to reduce some of the uncertainties of a novice therapist. However, the directive style of supervision may focus more on published treatment guidelines than prior clinical experience, and therefore the focus may shift to a nomothetic view that expects all clients to respond in a similar manner. This empirical stance may ignore the uniqueness of many clinical situations and can minimize the value of an idiographic approach to assessment and therapy. Furthermore, a directive approach tends to elevate the supervisor into the role of teacher or expert, which may push the trainee into the role of a passive student. This power shift can, in turn, elicit either naive compliance or even a rebellious rejection of supervisor's guidance.

Highly structured approaches may be most appreciated by novice therapists (Stoltenberg *et al.*, 2014) and their structured treatment guidelines seem most relevant to the treatment of highly conscribed problems, such as smoking cessation (Baker, McFall & Shoham, 2008). However, many emotional and cognitive struggles require a more complex approach to therapy. Effective therapists remain flexible and willing to adjust their approach to therapy as the treatment progresses (Wampold, 2011). Thus, by itself, directive guidance is limited, regimented, and can become far removed from the idiosyncrasies of clinical practice. However, directive guidance can be easily combined with other supervisory strategies. In most situations, the supervision of psychotherapy requires additional strategies, including a supportive working alliance between supervisor and trainee, a willingness to adapt the supervision to the unique situation that arises with each trainee, and the use of Socratic exploration to promote trainee growth and maturity as the trainee moves toward becoming an independent professional. These issues will be explored in additional review articles.

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References

ASSOCIATION FOR COUNSELOR EDUCATION AND SUPERVISION. (2011). Best practices in supervision. https://acesonline.net/

ASSOCIATION OF STATE AND PROVINCIAL PSYCHOLOGY BOARDS. (2015). Supervision guidelines for education and training leading to licensure as a health service provider. https://www.asppb.net/

ALLEN, G., SZOLLOS, S., & WILLIAMS, B. (1986). Doctoral students' comparative evaluations of best and worst psychotherapy supervision. *Professional Psychology: Research and Practice*, Vol. 17 (2), pp. 91-99.

ANDERSON, S., SCHLOSSBERG, M., & RIGAZIO-DIGILIO, S. (2000). Family therapy trainees' evaluations of their best and worst supervision experiences. *Journal of Marital and Family Therapy*, Vol. 26 (1), 79-91.

BAKER, T., MCFALL, R., & SHOHAM, V. (2009). Current status and future prospects of clinical psychology. *Psychological Science in the Public Interest*, Vol. 9 (2), pp. 67-103.

BAUCOM, D., & BOEDING, S. (2013). The role of theory and research in the practice of cognitive-behavioral couple therapy. *Behavior Therapy*, Vol. 44, pp. 592-602.

BEARMAN, S., WEISZ, J. R., CHORPITA, B. F., HOAGWOOD, K., WARD, A., UGUETO, A. M., & BERNSTEIN, A. (2013). More practice, less preach? The role of supervision processes and therapist characteristics in EBP implementation. *Administration and Policy in Mental Health and Mental Health Services Research*, Vol. 0 (6), pp. 518-529.

BEIDAS, R., BARMISH, A., & KENDALL, P. (2009). Training as usual: Can therapist behavior change after reading a manual and attending a brief workshop on cognitive behavioral therapy for youth anxiety? *The Behavior Therapist*, Vol. 32 (5), pp. 97-101.

BINDER, J. (1993). Is it time to improve psychotherapy training? *Clinical Psychology Review*, Vol. 13, pp. 301-318.

BINDER, J., STRUPP, H., BONGAR, B., LEE, S., MESSER, S., & PEAKE, T. (1993). Recommendations for improving psychotherapy training based on experiences with manual-guided training and research. *Psychotherapy*, Vol. 30 (4), pp. 599-600.

BORDERS, L. D. (2014). Best practices in clinical supervision: Another step in delineating effective supervision practice. *American Journal of Psychotherapy*, Vol. 68 (2), pp. 151-162.

BORDERS, L. D., GLOSOFF, H., WELFARE, L., HAYS, D., DEKRUYF, L., FERNANDO, D., & PAGE, B. (2014). Best practices in clinical supervision. *The Clinical Supervisor*, Vol. 33, pp. 26-44.

BROWN, E., MOLLER, N., & RAMSEY-WADE, C. (2013). Recording therapy sessions: What do clients and therapists really think? *Counselling and Psychotherapy Research*, Vol. 13(4), pp. 254-262.

BUTLER, D. (2002). Informed consent and patient videotaping. *Academic Medicine*, Vol. 77 (2), pp. 181-184.

CHOW, D., MILLER, S., SEIDEL, J., KANE, R., THORNTON, J., & ANDREWS, W. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy*, Vol. 52 (3), pp. 337-345.

CLARK, P., HINTON, W., & GRAMES, H. (2016). Therapists' perspectives of the cotherapy experience in a training setting. *Contemporary Family Therapy*, Vol. 38, pp. 159-171.

COHEN, A. (2018). The dangers of the ivory tower: The obligation of law professors to engage in the practice of law. *Loyola Law Review*, Vol. 50, pp. 623-673.

CUMMINGS, J. A., BALLANTYNE, E. C., & SCALLION, L. (2015). Essential processes for cognitive behavioral clinical supervision: Agenda setting, problem-solving, and formative feedback. *Psychotherapy*, Vol. 52 (2), pp. 158-163.

DAVIS, S., JOSEPHSEN, J., & MACY, R. (2013). Implementation of mental health simulations. *Clinical Simulation in Nursing*, Vol. 9, pp. e157-e162.

DEPUE, M., LIU, R., LAMBIE, G., & GONZALEZ, J. (2020). Examining the effects of the supervisory relationship and therapeutic alliance on client outcomes in novice therapists. *Training and Education in Professional Psychology*, (advance online copy).

DOWIE, A. (2000). Phronesis or 'practical wisdom' in medical education. *Medical Teacher*, Vol. 22 (3), pp. 240-241.

ERICSSON, K., KRAMPE, R., & TESCH-ROMER, C. (1993). The role of deliberate practice in the acquisition of expert performance. *Psychological Review*, Vol. 100(3), pp. 363-406.

FALKE, S., LAWSON, L., PANDIT, M., & PATRICK, E. (2015). Participant supervision: Supervisor and supervisee experiences of cotherapy. *Journal of Marital and Family Therapy*, Vol. 41 (2), pp. 150-162.

FRIEDBERG, R., GORMAN, A., & BEIDEL, D. (2009). Training psychologists for cognitive behavioral therapy in the raw world: A rubric for supervisors. *Behavior Modification*, Vol. 33 (1), pp. 104-123.

FRIEDBERG, R., & BRELSFORD, G. (2013). Training methods in cognitive behavioral therapy. *Journal of Cognitive Psychotherapy*, Vol. 27 (1), pp. 19-29.

FOLKES-SKINNER, J., ELLIOTT, R., & WHEELER, S. (2010). 'A baptism of fire': A qualitative investigation of a trainee counselor's experience at the start of training. *Counselling and Psychotherapy Research*, Vol. 10 (2), pp. 83-92.

FUNKENSTEIN, A. B., KESSLER, K. A., & SCHEN, C. R. (2014). Learning through the lens: Ethical considerations in videotaping psychotherapy. *Harvard Review of Psychiatry*, Vol. 22(5), pp. 316-322.

GAFNI, S., & HOFFMAN, S. (1991). teaching cotherapy: Instructional and supervisory processes. *Journal of Contemporary Psychotherapy*, Vol. 21 (4), pp. 285-289.

GANDOLFO, R., & BROWN, R. (1987). Psychology intern ratings of actual and ideal supervision of psychotherapy. *Journal of Training and Practice in Professional Psychology*, Vol. 1 (1), pp. 15-28.

GAZZOLA, N., DESTEFANO, J., THERIAULT, A., & AUDET, C. (2013). Learning to be supervisors: A qualitative investigation of difficulties experiences by supervisors-in-training. *The Clinical Supervisor*, Vol. 32, pp. 15-39.

GOLIA, G. (2015). On the importance of direct practice experience among clinical social work faculty. *Clinical Social Work Journal*, Vol. 43, pp. 325-333.

GONSALVEZ, C., BROCKMAN, R., & HILL, H. (2016). Video feedback in CBT supervision: Review and illustration of two specific techniques. *The Cognitive Behaviorist*, Vol. 9 (e24), pp. 1-15.

GOODYEAR, R. K. (2014). Supervision as pedagogy: Attending to its essential instructional and learning processes. *The Clinical Supervisor*, Vol. 33(1), pp. 82-99.

HAGGERTY, G., & HILSENROTH, M. (2011). The use of video in psychotherapy supervision. *British Journal of Psychotherapy*, Vol. 27 (2), pp. 193-201.

HENDERSON, C., CAWYER, C., & WATKINS, C. E. (1999). A comparison of student and supervisor perceptions of effective practicum supervision. *The Clinical Supervisor*, Vol. 18(1), pp. 47-74.

HILL, C., SPIEGEL, S., HOFFMAN, M., KIVLIGHAN, D., & GELSO, C. (2017). Therapist expertise in psychotherapy revisited. *The Counseling Psychologist*, Vol. 45 (1), pp. 7-53.

HILL, C., SULLIVAN, C., KNOX, S., & SCHLOSSER, L. (2007). Becoming psychotherapists: Experiences of novice trainees in a beginning graduate class. *Psychotherapy: Theory, Research, Practice, Training*, Vol. 44(4), pp. 434-449.

HIMELEIN, M., & PUTNAM, E. (2001). Work activities of academic clinical psychologists: Do they practice what they preach? *Professional Psychology: Research and Practice*, Vol. 32 (5), pp. 537-542.

HUHRA, R., YAMOKOSKI-MAYNHART, C., & PRIETO, L. (2008). reviewing videotape in supervision. Journal of Counseling & Development, Vol. 86, pp. 412-418.

JACOBSEN, C. H., & TANGGAARD, L. (2009). Beginning therapists' experiences of what constitutes good and bad psychotherapy supervision. *Nordic Psychology*, Vol. 61(4), pp. 59-84.

JOHNSON, E. (2019). Recommendations to enhance psychotherapy supervision in psychology. *Canadian Psychology*, Vol. 60 (4), pp. 290-301.

JOHNSON, Y., & MUNCH, S. (2010). Faculty with practice experience. *Journal of Social Work Education*, Vol. 46 (1), pp. 57-66.

KASLOW, N., FALENDER, C., & GRUS, C. (2012). Valuing and practicing competency-based supervision: A transformational leadership perspective. *Training and Education in Professional Psychology*, Vol. 6 (1), pp. 47-54.

KLEPAC, R., RONAN, G., ANDRASIK, F., ARNOLD, K., BELAR, C. ... DOWD, E. (2012). Guidelines for cognitive behavioral training within doctoral psychology programs in the United States. *Behavior Therapy*, Vol. 43, pp. 687-697.

LUKE, M., & HACKNEY, H. (2007). Group coleadership: A critical review. *Counselor Education and Supervision*, Vol. 46, pp. 280-293.

MARUNIAKOVA, L., & RIHACEK, T. (2018). How beginning cognitive behavioural therapists develop professional confidence. *Cognitive Behaviour Therapist*, Vol. 11, e5, pp. 1-19.

MCFALL, R. (2006). Doctoral training in clinical psychology. *Annual Review of Clinical Psychology*, Vol. 2, pp. 21-49.

MITCHELS, B., & BOND, T. (2010). Essential law for counsellors and psychotherapists. Sage.

NEGEGAARD, R. (2016). Practice experience and the new social work professor. *Social Work Research Journal*, Vol. 1 (1), pp. 44-55.

NEL, P., PEZZOLESI, C., & STOTT, D. (2012). How did we learn best? A retrospective survey of clinical psychology training in the United Kingdom. *Journal of Clinical Psychology*, Vol. 68 (9), pp. 1058-1073.

NIKENDEI, C., HUBER, J., EHRENTHAL, J., HERZOG, W., SCHAUENBURG, H., SCHULTZ, J., & DINGER, U. (2019). Intervention training using peer role-play and standardised patients in psychodynamic psychotherapy trainees. *Counselling and Psychotherapy Research*, Vol. 19(4), pp. 508-522.

OKECH, J., & KLINE, W. (2005). A qualitative exploration of group co-leader relationships. *Journal for Specialists in Group Work*, Vol. 30 (2), pp. 173-190.

OVERHOLSER, J. C. (2004). The four pillars of psychotherapy supervision. *The Clinical Supervisor*, Vol. 23 (1), pp. 1-13.

OVERHOLSER, J. C. (2010a). Clinical expertise: A preliminary attempt to clarify its core elements. *Journal of Contemporary Psychotherapy*, Vol. 40 (2), pp. 131-139.

OVERHOLSER, J. C. (2010b). Ten criteria to qualify as a scientist-practitioner in clinical psychology. *Journal of Contemporary Psychology*, Vol. 40 (1), pp. 51-59.

OVERHOLSER, J. C. (2019). Graduate training in psychotherapy: The importance of ongoing clinical activity for the training faculty. *Counselling and Psychotherapy Research*, Vol. 19, pp. 264-273.

PAGANO, J., KYLE, B., JOHNSON, T., & SAEED, S. (2017). Training psychiatry residents in psychotherapy: The role of manualized treatments. *Psychiatric Quarterly*, Vol. 88(2), pp. 285-294.

PEARSON, Q. (2006). Psychotherapy-driven supervision: Integrating counseling theories into role-based supervision. *Journal of Mental health Counseling*, Vol. 28 (3), 241-252.

PRETORIUS, W. (2006). Cognitive behavioural therapy supervision: Recommended practice. *Behavioural and Cognitive Psychotherapy*, Vol. 34, pp. 413-420.

RASSAFIANI, M., ZIVIANI, J., RODGER, S., & DALGEISH, L. (2008). Identification of occupational therapy clinical experience. *Australian Occupational Therapy Journal*, Vol. 55, pp. 1-11.

RAY, D., JAYNE, K., & MILLER, R. (2016). Master counselors as teachers: Clinical practices of counselor educators. *Journal of Mental Health Counseling*, Vol. 36 (1), pp. 78-93.

RECUPERO, P. R., & RAINEY, S. E. (2007). Liability and risk management in outpatient psychotherapy supervision. *Journal of the American Academy of Psychiatry and the Law Online*, Vol. 35(2), pp. 188-195.

REICHELT, S., & SKJERVE, J. (2000). Supervision of inexperienced therapists: A qualitative analysis. *The Clinical Supervisor*, Vol. 19 (2), pp. 25-43.

RONNESTAD, M. H. (2016). Is expertise in psychotherapy a useful construct? *Psychotherapy Bulletin*, Vol. 51 (1), pp. 11-13.

ROUNSAMANIERE, R. & ELLIS, M. (2013). Developing the construct of collaborative clinical supervision: The supervisee's perspective. *Training and Education in Professional Psychology*, Vol. 7 (4), 300-308.

SALTER, M., & RHODES, P. (2018). On becoming a therapist: A narrative inquiry of personal-professional development and the training of clinical psychologists. *Australian Psychologist*, Vol. 53(6), pp. 486-492.

SHARPLESS, B., & BARBER, J. (2009). A conceptual and empirical review of the meaning, measurement, development, and teaching of intervention competence in clinical psychology. *Clinical Psychology Review*, Vol. 29 (1), pp. 47-56.

SHRAGAY, S., & HOFFMAN, S. (2015). Reflections of a psychology intern in participant-supervision. *International Journal of Psychotherapy*, Vol. 19 (2), pp. 124-129.

SIMPSON-SOUTHWARD, C., WALLER, G., & HARDY, G. (2017). How do we know what makes for "best practice" in clinical supervision for psychological therapists? *Clinical Psychology & Psychotherapy*, Vol. 24(6), pp. 1228-1245.

SKOVHOLT, T., RONNESTAD, H., & JENNINGS, L. (1997). Searching for expertise in counseling, psychotherapy, and professional psychology. *Educational Psychology Review*, Vol. 9 (4), pp. 361-369.

SMYTHE, E., MACCULLOCH, T., & CHARMLEY, R. (2009). Professional supervision: Trusting the wisdom that 'comes'. *British Journal of Guidance and Counseling*, Vol. 37 (1), pp. 17-25.

SPEER, S. A., & HUTCHBY, I. (2003). From ethics to analytics: Aspects of participants' orientations to the presence and relevance of recording devices. Sociology, Vol. 37(2), pp. 315-337.

STOLTENBERG, C. (1997). The integrated developmental model of supervision. *Psychotherapy in Private Practice*, Vol. 16 (2), pp. 59-70.

STOLTENBERG, C., BAILEY, K., CRUZAN, C., HART, J., & UKUKU, U. (2014). The integrative developmental model of supervision. C.E. Watkins & D. Milne (eds), *International Handbook of Clinical Supervision* (ch. 28). New York: Wiley.

STORM, C., TODD, T., SPRENKLE, D., & MORGAN, M. (2001). Gaps between MFT supervision assumptions and common practice: suggested best practices. *Journal of Marital and Family Therapy*, Vol. 27(2), pp. 227-239.

THÉRIAULT, A., GAZZOLA, N., & RICHARDSON, B. (2009). Feelings of incompetence in novice therapists: Consequences, coping, and correctives. *Canadian Journal of Counselling and Psychotherapy*, Vol. 43(2), pp. 105-119.

TOPOR, D., AHNALLEN, C., MULLIGAN, E., & DICKEY, C. (2017). Using video recordings of psychotherapy sessions in supervision: Strategies to reduce learner anxiety. Academic Psychiatry, Vol. 41(1), pp. 40-43.

TRUELL, R. (2001). The stresses of learning counselling: Six recent graduates comment on their personal experience of learning counselling and what can be done to reduce associated harm. *Counselling Psychology Quarterly*, Vol. 14(1), pp. 67-89.

VAKOCH, D., & STRUPP, H. (2000). The evolution of psychotherapy training: reflections on manual-based learning and future alternatives. *Journal of Clinical Psychology*, Vol. 56 (3), pp. 309-318.

WAMPOLD, B. (2011). *Qualities and actions of effective therapists*. American Psychological Association: Education Directorate.

WATKINS, C. E., BUDGE, S., & CALLAHAN, J. (2015). Common and specific factors converging in psychotherapy supervision. *Journal of Psychotherapy Integration*, Vol. 25(3), pp. 214-235.

WATKINS, C. E. (2016). A unifying vision of psychotherapy supervision. *Journal of Unified Psychotherapy and Clinical Science*, Vol. 4 (1), pp. 21-35.

WATKINS, C. E. (2018). The generic model of psychotherapy supervision: An analogized research-informing meta-theory. *Journal of Psychotherapy Integration*, Vol. 28(4), pp. 521-536.

WEARS, R. (2004). The limits of techne and episteme. *Annals of Emergency Medicine*, Vol. 43(1), pp. 15-16.

WECK, F., KAUFMANN, Y. M., & WITTHÖFT, M. (2017). Topics and techniques in clinical supervision in psychotherapy training. *The Cognitive Behaviour Therapist*, Vol. 10, e3, pp. 1-17.

WESTERFIELD, J. (2009). Supervision of psychotherapy: Models, issues, and recommendations. *The Counseling Psychologist*, Vol. 37 (2), pp. 296-316.

ZIMMERMAN, E. (2013). Should law professors have a continuing practice experience (CPE) requirement? *Northeastern University Law Journal*, Vol. 6 (1), pp. 131-188.

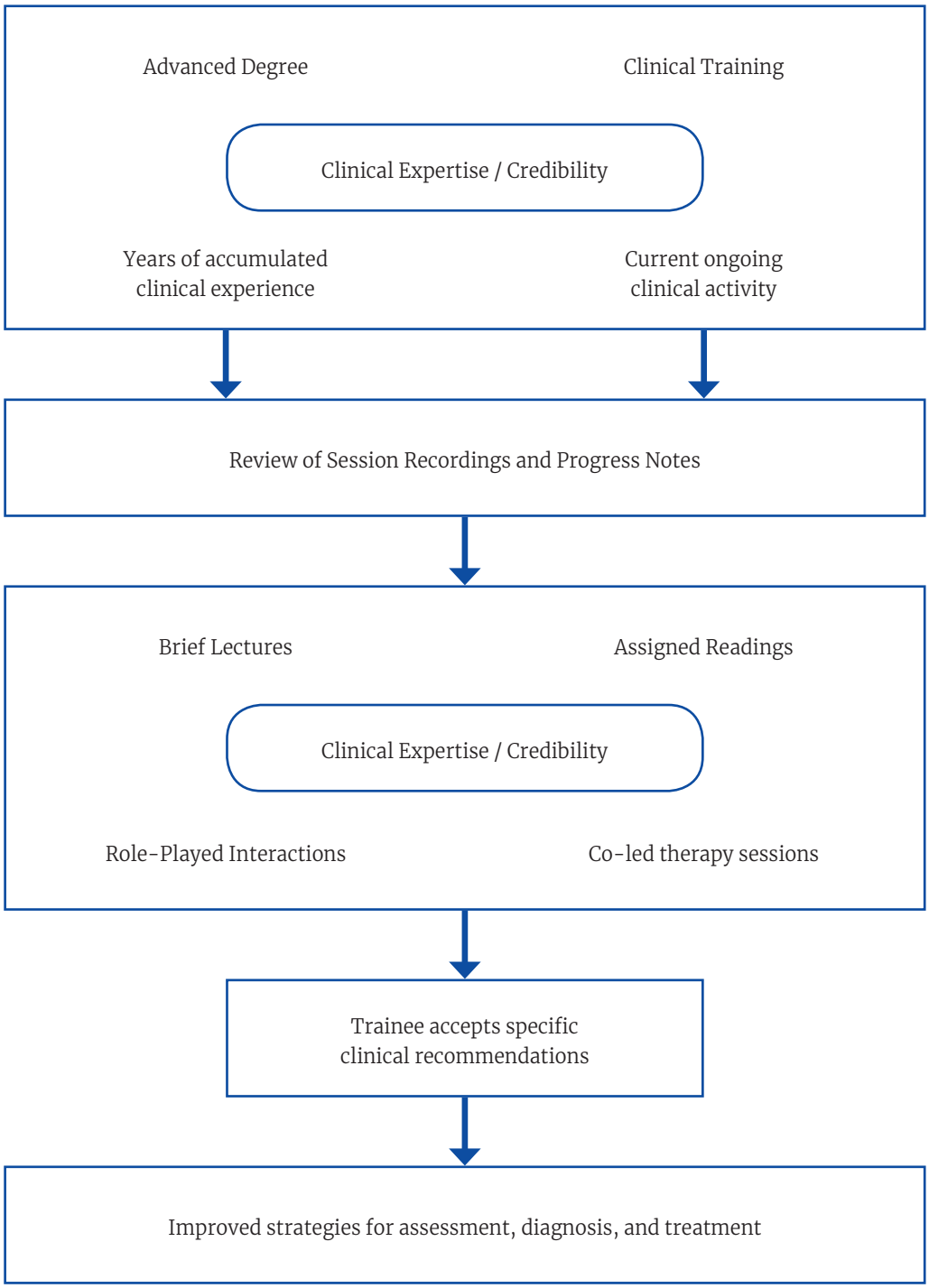

Figure 1. *Directive Guidance in Clinical Supervision*

"Procrustean" and "Eclectic" Schools of Psychotherapy

Seymour Hoffman

Abstract: There exist today many therapists, who have graduated from the "Procrustean" school of psychotherapy (Hoffman, 1992). They come from all sorts of orientations, persuasions and disciplines, and they have very firm beliefs: in their theory of human nature; of the causes of psychopathology; and the means to ameliorate the latter. Other views are usually rejected, or they are relegated to a minor or insignificant position. These therapists believe that they are equipped with a small 'toolbox' that contains a sturdy, unique, eighteen-carat gold tool that they boldly and confidently apply to all problems, situations, and people that seek their professional attention. So, we re-iterate Maslow's (1966) caution, *"If the only tool that you have is a hammer, you will treat everything as if it was a nail"*: a maxim that is often dismissed with a smirk and derisive smile.

Key Words: Psychotherapy Procrustean, Eclectic, Flexibility

The "Procrustean bed" [1] is an arbitrary standard to which 'exact' conformity is usually enforced. Therapists, who employ such *"Procrustean-bed"* approaches to psychological treatment, basically have a single method or intervention that they tend to use on everyone. Rather than modifying their therapeutic approach to fit the needs of different unique individuals (their clients), they insist that these clients conform to their preferred method.

Thus, everyone that they see in therapy will get whatever the (the therapist) likes to dispense, whether or not it is what the client really needs, or what is suitable. So, regardless of one's presenting complaint (i.e., anxiety, depression, panic, OCD, trauma, stress, etc.), a "Procrustean-bed" practitioner will provide only – for example – DBT, or ACT, or standard CBT, or psychoanalysis, or mindfulness, or hypnosis, or EMDR, or medications.

During my years as a student, clinical intern, staff psychologist and then supervisor, I have come across many examples of the "procrustean" therapeutic approach and therefore

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there are recorded below several egregious examples of the above:

1. In my first year of internship in clinical psychology over a half century ago, my supervisor, a seasoned Freudian psychoanalyst, told me about a Jewish female patient, who had suffered from severe anxiety and depression. In one session, she informed him that she had a dream about *"Tisha B'Av"*, (the 9th day of the Hebrew month of Av), which is the saddest day in the Jewish calendar as it commemorates the destructions of the first and second Temples in Jerusalem, several thousand years ago, about which observant Jews fast for 25 hours. With great pride, he interpreted the dream to mean that the patient wished to become pregnant by her father (Av). (In Hebrew, *"Tisha"* is *"9"*; *"B"* means *"in"*; and *"Av"* also means *"Father"*). He claimed that, in the following week, the patient had appeared less depressed as result of his dynamic interpretation (*Oedipus Complex*).

This writer is of the opinion that what produced the improvement was the patient's feeling that, if a successful doctor could have such outlandish thoughts, then there was hope for her.

2. A psychodynamic colleague of mine made the following points to a new group of interns, working in the student counselling centre, regarding how to conduct the initial interview with a patient: *"Inform the patient that you will be meeting with him/her on a weekly basis for a year (Parkinson's Law); and ask them to bring in dreams to the sessions and to free associate; and don't ask questions or raise topics not brought up by the patient"*.

3. A 30-year old patient was being treated by a clinical intern for a year for marital difficulties, but with little success. When asked by his new supervisor why he didn't invite the patient's spouse for a conjoint meeting, his response was, *"I don't know how to do marital therapy"*.

4. A psychotherapist colleague of mine was treating a patient, who had a severe obsessive-compulsive disorder, and who had been in dynamic therapy for two years, even though the professional literature clearly indicates that the above approach is ineffective and counter-productive with this disorder, and that a cognitive-behavioural approach is both evidence- based and is the treatment of choice.

5. A 16-year old 'religious' boy had developed a severe case of agoraphobia and had refused to attend school for several months. His behaviour-oriented therapist, after several months of failure in attempting to reduce his anxiety, via desensitization and other behavioural techniques, terminated treatment and recommended psycho-pharmacological treatment with a psychiatrist. The boy, however, refused to take the medication and therefore chose to see another psychologist, who was able to help the patient address and cope with his fears of acting out his homosexual impulses and he returned to school after a half-year of dynamic therapy.

Fortunately, there are also several practitioners from the eclectic psychotherapy school, who practice prescriptive eclectic psychotherapy or technical eclectic psychotherapy.

Prescriptive Eclectic Psychotherapy

The focus of such 'prescriptive' eclectic psychotherapy, described in 1978 by Richard E. Dimond and colleagues, is to create a personalized treatment plan for each client that is

based on a combination of different theories and techniques. This sort of therapy allows the therapist to use multiple theoretical approaches, but these must be rooted in evidence from psychological research. The psychotherapist must not only choose the type of psychotherapy used, but also the type of therapeutic relationship that should be utilized.

Technical Eclectic Psychotherapy

Technical eclectic psychotherapy focuses only on using multiple techniques and ignores the theoretical background of those techniques. In this form of eclectic therapy, the therapist uses a variety of techniques, based on what is expected to help the patient. Theory is not considered an important factor in this approach, as what only matters are the techniques used. Depending on the techniques selected by the therapist, the methods of treatment may therefore come from similar psychological schools, or from completely different ones, or from the therapist's thought.

Comparison with Integrative Psychotherapy

The terms "integrative psychotherapy" and "eclectic psychotherapy" are sometimes used interchangeably, but the two terms are not synonymous. Both 'integrative' and 'eclectic' psychotherapy combine the use of multiple psychological theories. 'Integrative' psychotherapy tends to place greater emphasis on the theories that are being combined, while 'eclectic' therapy tends to be more outcome-focused. An 'eclectic' psychotherapist will use whatever theory will help his or her patient; and an 'integrative' psychotherapist will use one theory to complement another.

Having concepts and techniques from different therapeutic approaches allows one to use the most appropriate tools for each situation instead of those indicated by a specific theory; this increases the effectiveness of the interventions. It also allows more easily apply holistic treatments, that is, directed to the person as a whole.

Everyone has certain characteristics that set them apart from the rest; therefore, adapting the interventions to each client can become fundamental. The 'eclecticism' is very useful in this sense, since the increase in the range of treatments makes it possible to cover – better – the different needs of the clients.

The Flexibility and Creativity of the Therapist

These 'assets' are essential for being successful in psychotherapy. The therapist '*par-excellence*' who is able to demonstrate these traits in the treatment room was Milton Erickson, the "Einstein of treatment" (Haley, 1986). Erickson believed that, "*Each person is a unique individual. Hence, psychotherapy should be formulated to meet the uniqueness of the individual's needs, rather than tailoring the person to fit the Procrustean bed of a hypothetical theory of human behavior*". (Zeig & Lankton, 1988)

Flexibility should also be demonstrated with regards to the length of the sessions, time between sessions, and involvement of any significant others of the patient in the treatment (Hoffman & Gottlieb, 2016) as well as the use of co-therapists (Hoffman *et al.*, 1994) and consultants (Hoffman *et al.*, 1994) in the treatment when indicated.

Flexibility in perceiving and evaluating things and situations is a '*sine qua non*' for creative thinking. To be a creative therapist requires originality and unconventionality in one's thinking and one's actions and the willingness to take risks. Quaytman, (1974) concluded, "*... what makes a creative psychotherapist is the*

extent to which she can risk chance, utilize diverse approaches to therapy, avoid dogma which denies a person's uniqueness, and expand her own life experience." "Thinking out of the box", at times, is important in order to meet the requirements of the patient and be an effective psychotherapist (Deutch & Hoffman, 2018; Hoffman & Kuperman, 1990; Hoffman & Gottlieb, 2014)

Arnold Lazarus (1993) is of the opinion that relationships of choice are no less important than techniques of choice for effective psychotherapy. A flexible repertoire of relationship styles, plus a wide range of pertinent techniques seem to enhance treatment outcomes. Decisions regarding different relationship stances include when and how to be directive, supportive, respective, cold, warm, tepid, formal, or informal. If the therapist's style differs markedly from the patient's expectations, positive results are unlikely.

The use of humour in certain situations can also be surprisingly effective in psychotherapy. (Hoffman, 2008) Killinger (1987) points out that humour appears to releases patients from a narrow, ego-centred focus while loosening rigid, circular thinking. Thought processes that had become ruminatively stale and closed are interrupted through humour, and a new fresh perspective emerges. *"The shift in focus facilitated by humour may then serve to unlock or loosen the rigid repetitive view that individuals often hold regarding their particular situations."*

Perry and his colleagues (1985) concluded, *"Too often patients receive the treatment known best to, or practiced primarily by, the first person they consult, rather than from which they might benefit"*. Trainees and supervisors also are likely to spend the bulk of their time together discussing phenomenology, or psychodynamics, and devote little, or no, time to the choice of treatment.

There is great value in having trainees exposed at the outset of their training to the non-dogmatic notion that many treatments are possible and that no one teacher or supervisor has a monopoly on the truth. They should be taught to determine what treatment is most likely to be optimal even if they don't know how to do it. Learning when – and how to refer onwards – is an important part of clinical training. Instilling the notion of flexibility and openness at an early juncture of their training is crucial. Interns should be exposed to a dynamic atmosphere where different views are presented and creativity and experimentation are encouraged, to an environment enriched by the tension of clinical decision making and feedback.

Author

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Endnotes

1. **Procrustean bed**: A scheme or pattern into which someone or something is arbitrarily (or ruthlessly) forced, disregarding any resulting or obvious harm: derived from the Greek myth of Procrustes, a bandit in Attica, who either stretched his victims on a rack, or chopped off their legs, so as to fit them into an iron bed. He was captured and fitted into his own bed by Theseus.

References

DEUTCH, A. & HOFFMAN, S. (2019). "Thinking Outside of the box": An Unconventional Intervention. *International Journal of Psychotherapy*, Vol. 23, No. 2, pp. 57-60.

DIMOND, R. E., HAVENS, R. A. & JONES, A. C. (1978). A conceptual framework for the practice of prescriptive psychotherapy. *American Psychologist*, 33, pp. 239-248.

HALEY, J. (1986). *Uncommon Therapy.* New York: W.W. Norton & Co.

HOFFMAN, S. (1992). Procrustean Psychotherapy. *Journal of Integrative and Eclectic Psychotherapy*, 11, pp. 5-7.

HOFFMAN, S., GAFNI, S. & LAUB, B. (1994). *Co-therapy with Individuals, Families and Groups.* Northvale, NJ: Jason Aronson, Inc.

HOFFMAN, S., GEDANKEN, S. & LAHAT, E. (1994). Intervention by a Consultant in Overcoming Therapeutic Impasse. *International Journal of Short-Term Psychotherapy*, 9, (1), pp. 61-65.

HOFFMAN, S. (2008). Humor as Strategy. *Journal of Critical Psychology, Counseling and Psychotherapy, 2008, 8, 1, pp. 21-22.*

HOFFMAN, S. & GOTTLIEB, F.A. (2016). Single Meeting with Family Members of Adults in Individual Therapy. *International Journal of Psychotherapy*, Vol. 20, No. 3, pp. 18-22.

HOFFMAN, S. & KUPERMAN, N. (1990). Indirect Treatment of Traumatic Psychological Experiences: The Use of TAT Cards. *American Journal of Psychotherapy*, 44, (1), pp. 107-115.

HOFFMAN, S. & GOTTLIEB, F. (2014). Flooding and Desensitization in Treating O. C. D.: A Case Study. *International Journal of Psychotherapy*, 18, 1, pp. 27-34.

KILLINGER, B. (1987). Humor in Psychotherapy: A shift to a new perspective. In: W. F. Fry & W. A. Salameh (Eds.), *Handbook in Humor and Psychotherapy: Advances in the Clinical Use of Humor,* (pp. 21-40). Sarasota, FL: Professional Resources Exchange.

LAZARUS, A. A. (1993). Tailoring the Therapeutic Relationship, or Being an Authentic Chameleon. *Psychotherapy: Theory, Research, Practice, Training*, 30 (3), pp. 404–407.

MASLOW, A. H. (1966). *The Psychology of Science: A Reconnaissance.* New York: Harper & Row.

PERRY, S., FRANCES, A. & CLARKIN, J. (1985). *A DSM-3 Casebook of Differential Therapeutics.* New York: Brunner.

QUAYTMAN, W. (1974). What makes a creative psychotherapist. *Journal of Contemporary Psychotherapy*, 6, pp. 168-179.

ZEIG, J. K. & LANKTON, S. R. (Eds.). (1988). *Developing Ericksonian Therapy: State of the Art.* New York: Brunner/Mazel.

Using Imagery Work to treat 'Appearance-Concerns' in an adolescent female: A case study

Carol Valinejad & Emma Parish

Abstract:

Background: 'Imagery Rescripting' (ImRs) has been found to be an effective adjunct to therapy, especially when treating individuals with Body Dysmorphic Disorder and some other disorders. However, sometimes, clients are unable to identify a clear incident which triggered their 'Appearance-Concerns'. In such cases, imagery interventions can be adapted to suit the psychological presentation of the client.

Objective: This article aims to provide a practice-based example of how imagery-based interventions can assist an adolescent girl recover from her 'Appearance-Concerns'.

Method: The client was offered imagery-based interventions, as part of her Cognitive Behavioural Therapy (CBT) treatment to target her 'Appearance-Concerns'.

Conclusion: This case study provides an indication that targeting the 'appearance concern' in BDD, rather than the emotional consequences of BDD, will provide more clinical and cost-effective treatments for these individuals than those treatments that primarily target the emotional consequences of the disorder.

Key Words: 'Appearance-Concerns', Body Dysmorphic Disorder, Imagery Work, Case Study

Introduction

Concerns about appearance are prevalent amongst teenagers and social models may provide an explanation for why. During this phase of development, individuals are experiencing a time of psychological and social change, which transforms them from child-

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hood to young adult independence through puberty; a physiological and chemical change that leads to sexual maturity. Puberty and adolescence are often emotionally intense. Whilst the individual, as a child, may have been unselfconscious about their appearance, with the onset of puberty, their physical appearance may become a primary concern for them. These 'Appearance-Concerns' are often fuelled by popular icons in the media and via the world of advertising that provide compelling (so-called) answers in the form of idealised (and often unrealistic) models of beauty, which can lead to exacerbation of 'Appearance-Concerns'. This is due to the unrealistic nature of these idealistic bodies that means few adolescents can meet the standards of womanly and manly physical appearances, as portrayed in the media. Comparing themselves to these ideals often leads to feeling dissatisfied about their own appearance and may lead to efforts in changing their appearance and becoming pre-occupied by their 'flaws' (Ferguson *et al.*, 2011).

Whilst 'Appearance-Concerns' might be an understandable response to social pressures in respect to achieving ideals in appearance, there is a group of individuals whose presentation develops to a level of severity that it actually disrupts their development and psychosocial functioning (Greenberg *et al.*, 2010). Such individuals have sometimes attracted a diagnosis of Body Dysmorphic Disorder (BDD). In fact, it is estimated that BDD affects 2.2% of the UK adolescent population (Veale *et al.*, 2016).

The diagnosis of Body Dysmorphic Disorder is included within the Diagnostic and Statistical Manuel of Mental Disorders, 5th edition (DSM-V) as an obsessive-compulsive related disorder. There are four diagnostic criteria for Body Dysmorphic Disorder (BDD). Firstly, the individual has persistent and intrusive preoccupations that one or more aspect of their appearance is flawed or defective (Buhlmann & Wilhelm, 2004). Secondly, at some point during the course of the disorder, they have performed repetitive behaviours – such as mirror checking, excessive grooming, or skin picking. Thirdly, these preoccupations cause clinically significant distress or impairment in an individual's important areas of functioning, such as in their social life. And lastly, the 'Appearance-Concerns' are not better explained by concerns with body-fat and weight, leading to a more relevant diagnosis of an eating disorder.

Individuals with BDD are said to have delusions that others take specific notice of them, or perhaps even bully them, due to the way they look. BDD is often associated with high levels of anxiety, in particular, social anxiety and avoidance, depressed mood and low self-esteem. Whilst some clients may describe themselves as 'unattractive', others may use more derogatory terminology – such as 'ugly', 'hideous' or 'repulsive' (Wilhelm *et al.*, 2013). Treatment efficacy for BDD has been mixed, with some studies revealing improvements in BDD using CBT, between 12 and 60 therapy sessions (Harrison *et al.*, 2016). Other studies revealed improvement after 5 to 8 years (Brauser, 2011). Given that individuals with a diagnosis of BDD present with a complex array of imaginal, behavioural and emotional difficulties, one explanation for this variation in treatment outcomes across studies is because researchers target different problems within therapy (Phillips & Hollander, 2008; Witte *et al.*, 2012). It is therefore suggested that treatments that target the individual's 'Appearance-Concerns' are more clinically and cost-effective when treating BDD, rather than treatments that primarily target the psychological consequences of BDD, such as depression, anxiety and suicidality (Valinejad, 2015).

More recent studies have found imagery interventions as lending themselves to more tar-

geted and delivery of efficient psychotherapy when treating 'Appearance-Concerns' with individuals with a diagnosis of BDD (Wilson *et al.*, 2016; Ritter & Strangiu, 2016; Grocholewski, 2018).

"Imagery Rescripting" is an evidence-based therapeutic technique addressing specific memories of earlier experiences associated with present problems. By imaging that the course of events is changed in a more desired direction, the meaning associated to those events can be changed and powerful therapeutic effects have been found. It is described as a three-phase procedure (Arntz & Weertman, 1999), whereby a client imagines some of the various early adverse experiences that they had during childhood – firstly, from an adult perspective. Clients are then asked to relive their original experience – from a child's perspective, then as adults; and then – finally – they imagine that they are watching what happens to their younger self and that they are able to intervene as an adult. Imagery Rescripting has increased in use during treatments for those who experience distressing images (Holmes, Arntz & Smucker, 2007).

Whilst 'Imagery Rescripting' was initially developed for the treatment of Post-Traumatic Stress Disorder (PTSD) and other personality disorders, recent research, conducted by Ritter and Stangier (2016), found that – post-intervention – there was a significant decrease in the distress, vividness and perceived beliefs that are associated with intrusive images and memories in five out of six patients, with a 26% improvement from baseline BDD symptom severity, maintained at a two-week follow-up. With respect to co-morbid depressive symptoms, there was also a significant reduction at follow up (24%) for all patients, indicating that 'Imagery Rescripting' may be beneficial at treating those individuals with BDD who have other co-morbidities.

Similar results were found by Willson *et al.* (2016) and these studies have indicated the efficacy of 'Imagery Rescripting' as a possible treatment for clients with BDD who report intrusive images. In their study, four out of six participants had reduced appearance preoccupations and distress following the use of 'Imagery Rescripting', with changes occurring within a week post-intervention and for six months thereafter. These results highlight the importance of considering imagery-focused interventions when treating clients with BDD, dependent on their specific symptomology, as 'Imagery Rescripting' seems to facilitate a change in an individual's aversive mental images that underlie their disorder, into a more comfortable presentation that results in a reduction of symptoms.

This article aims to provide some indications about the efficacy of the inclusion of imagery work within cognitive-behavioural therapy, when treating appearance-concerns in an adolescent female.

Case Study

A case study of a 13-year-old girl from an English background is described. She is an only child and lives with her parents. She was a very attractive and pretty girl, with very long brown hair. In order to preserve her anonymity, she will be called 'Elizabeth'. She also provided consent for the clinical details of her case to be used for the purposes of this article. Therapy took place remotely, via a video link, during the Covid-19 pandemic. In the referral letter, her presenting problems were described as anxiety, depression, suicidal ideation, and self-harming behaviour (using scissors). Although the contents of her thoughts were not revealed in the letter, she was described as having "distressing and horrible" thoughts, which her parents were unaware of. Further, she was noted to have had this problem for the

past 7 to 8 months, but her parents were only made aware of it within 3 weeks of her referral taking place. This is consistent with Phillips' (2007) postulation that clients may conceal their 'Appearance-Concerns', as they worry that these may be misunderstood, therefore they may only disclose symptoms of depression and/or anxiety within social situations, due to shame and embarrassment about being thought of as being vain. Elizabeth's parents had sought psychological assistance for her, when her self-harming behaviour had started two weeks prior. This was when Elizabeth considered things were at their worst.

Psychological Therapy

Elizabeth was referred for an initial 6 CBT sessions, but (for reasons which will be explained later on), a further 6 sessions, totalling 12, were requested in order to complete the therapy objectives. During her first appointment, Elizabeth confirmed that she was suffering from the presenting symptoms, as detailed in her referral letter. Consistent with the area of specialism of the service, she was asked whether she had suffered any psychological trauma recently that might have triggered these symptoms. She explained how she was presently being bullied at school by a male pupil, who was calling her names such as "pancake face" and "witch's nose". She found this name-calling particularly distressing, as it exacerbated her 'Appearance-Concerns'. These concerns were explored further, and she reported that she had always had these concerns, from as far back as she can remember and she could not link them to any particular trigger. Although, at the time of referral she had not been specifically diagnosed with BDD, the symptoms she described would qualify her for such a diagnosis.

She described the content of these concerns and the impact that it has had upon her life. She reported that she had never been happy with the way that she looked. On the days when she felt particularly distressed by her appearance, she would cry for hours in her bedroom, to the extent that she felt quite suicidal. This had tended to have happened several nights per week, which she would conceal from her parents because she did not wish them to know how she felt about herself. There would be occasions when she felt so distressed about the way that she looked that she could not face going into school, so she would give her parents an excuse saying that she was too unwell to go. At these times, her parents believed her, and she was allowed to stay off school and she reported that she would miss at least a couple of weeks from school per term, on account of her 'Appearance-Concerns'.

She also described that there were parts of her face that she did not wish people to see and she had adopted a number of 'safety behaviours' to prevent people from seeing them. For example, she reported how she tended to sit in the same place when at dinner with her parents – so as to prevent them seeing her from a certain angle, because of her perception that, if they did, they would see how ugly she was. Further, the country was currently in lockdown due to Covid-19 and so she tended to stay in her pyjamas all day. She explained that she did this because she did not want to risk her parents expressing disapproval of what she wore, if she was dressed in clothes. In fact, she tended to allow her mother to purchase clothes for her to avoid the risk of any disapproval, if she had purchased them herself.

She reported that she tended to avoid going out socially, as much as possible, because she believed that, if she did, people would judge her because of the way she looked. In addition, she reported associated physical symptoms whenever she felt distressed about her appearance. These included headaches, "butterflies" in her stomach, and feeling sweaty. Elizabeth re-

ported a long history of concealing this problem from her parents, and she had grown quite skilled at "putting on a brave face", and, although she constantly felt unhappy about the way she looked, she was able to portray being happy on some days, but not on others.

Consistent with the trauma-informed approach to therapy of the psychology department, Elizabeth was first introduced to the trauma-focussed CBT model, given the context of the bullying she was suffering from (Ehler & Clarke, 2008). This approach was utilised up to session 4, when a review of her treatment took place. It seemed unlikely, at this point, that any treatment goals were going to be realised as – although Elizabeth had reported that she had learned new techniques so as to be more assertive with her aggressor and that she had benefitted from the relaxation therapy – she continued to feel depressed about the way she looked.

It became apparent at this stage that it was her 'Appearance-Concerns' that were at the heart of her problems and not so much the trauma that she was experiencing as a result of the bullying. A recommendation was therefore made to her referrers to fund her for an additional 6 sessions and the remaining 8 sessions were targeted towards her 'Appearance-Concerns'.

Whilst Elizabeth was not asked to do a behavioural experiment, an example of one was discussed with her, in order to help her to entertain the view that her beliefs about herself may not be accurate. The analogy of conducting a survey about her appearance was discussed, and the responses were pre-empted. She was advised that the only way that she would really know if she was correct in her perceptions about her appearance was if she interviewed a large number of people to ask them what they thought about her looks. Based on the therapist's perception of how she looked, and a genuine belief in predicting how people would respond, she was advised that the results from such a survey would likely reveal that (about) 70 % of people would say that she had good looks and 30% might say not. She was invited to reflect on these figures and to pass comment upon them. She seemed to think that the predicted results were a reasonable analysis of what could be expected from such a survey.

A discussion about the extent to which she could be confident about her own beliefs about her appearance followed. The use of metaphor was used to assist her to transform the meaning of her 'Appearance-Concerns' (Stott *et al.*, 2012). The metaphor of a snowball was used to explain how her belief about her appearance had grown over the years, until her convictions had intensified to its current level. This paved the way to utilising imagery work to assist her in "melting the snowball" (Hackman *et al.*, 2013).

The actual standardised method of Imagery Rescripting (as detailed in the literature) was not employed as Elizabeth was not able to identify an historical occasion when her appearance concerns started. Instead, the imaginary work that was utilised in her case, was adapted to suit the particular formulation of her problem. Guided imagery was used to assist her create a scene in her imagination where she could see herself on a beach in the hot sun. She was encouraged to imagine that she could see a massive snowball on the beach, where she could observe it being gradually melted away by the temperature of the hot sun. She was able to engage in this process to the point that she could see in her imagination that the massive snowball had melted into a puddle in the sand, which eventually dried up because of the high temperatures. She was then invited to comment on how the imagery made her feel. She reported that she felt a lot happier, as she saw the snowball melt away. This intervention was then followed by instructing her through

a deep progressive relaxation in order to consolidate the 'emotional shift" that she had achieved via the imagery intervention.

Evaluation of Therapy

By the time that her 12 sessions of CBT were complete, Elizabeth was asked to rate her progress on a 10-point scale, where 10 was complete recovery and 0 was no recovery. She rated herself at an 8. She described the extent of her recovery in the following ways: Elizabeth reported that now she doesn't cry as much over her looks. She said that she used to do hours of crying every day, or every other day. In the past couple of weeks, she had only cried maybe a couple of times for half an hour, reflecting how this reduction represented her "feeling good" about herself. In addition, she reported that her suicidal ideation and self-harming behaviour had ceased.

She also reported a marked reduction in her avoidant behaviour. Prior to the therapy, she used to spend time in her room to avoid seeing her parents, but now she had started to interact with them more. Further, she had stopped utilising the safety behaviour at dinner time, when she had sat in a fixed place so as to prevent her parents from seeing a certain side of her face, which she disliked. She now tended to change the place where she sat at dinner time and was more flexible. She had begun to socialise more with her friends, according to the government guidelines at the time, and, even though the whole country was in lock-down during her treatment, she was looking forward to the prospect of going back to school.

She had also started to buy clothes for herself, using online orders. This was a significant change in her earlier behaviour where she tended to allow her mother to choose her clothes to prevent her parents judging the way that she looked if she bought her own clothes. In addition, she had stopped wearing pyjamas in the house all day, as a means to avoid her parents perceived judgements about the way she looked: she had started to wear day clothes instead.

She was now able to express a liking for her looks. Prior to the therapy, she reported that she did not like anything about the way she looked. By the time it was complete, she was able to say that she liked her eyebrows and her hair and – although she was not "a big fan" of the way that her body looks – she now feels much better about it than she used to. She had also started to share her feelings with her mother, whereas – prior to treatment – she would conceal the way that she felt from her parents.

During the final session, her mother was invited in to comment on Elizabeth's progress since the treatment. Even though her mother was not aware of the content of the sessions, she reported that Elizabeth presented as being in a much better "mental place" than she was prior to therapy. Elizabeth was also invited to complete a customer satisfaction questionnaire by the organisation that had referred her to our service, and she provided the following comment:

> *"My experience has been good, sadly we were on lockdown in this period of time, so it was a little difficult at times. However, they have helped me in the ways I needed to be helped and have made me mentally a better person today".*

Discussion and Conclusions

The objective of this case study article was to demonstrate how using imagery work within CBT had assisted a teenage girl to recover from her 'Appearance-Concerns'. Although, she did not have a diagnosis of BDD at the time of her referral, her presenting symptoms would have certainly qualified her for such a diagnosis.

There are a number of factors arising from this therapy, which is worth commenting upon. It was found from this case study that targeting her appearance concern, rather than the emotional consequences of these concerns, provided the most clinical and cost-effective approach to treatment delivery. Therapy commenced with a trauma-informed approach, but it did not provide a complete resolution to the client's concerns. According to the literature on treatment efficacy for BDD, length of treatment is variable across studies: some lasting up to 8 years. This case study provides an indication that, if treatment targets the 'Appearance-Concerns' first, treatment goals can be achieved sooner.

Research studies in connection with BDD and imagery have largely utilised techniques from Imagery Rescripting (Morino *et al*., 2017). This case study did not use this approach, as the client did not originally identify a clear trigger for her 'Appearance-Concerns'. Instead an imagery intervention, which was tailormade to her particular concerns, was used. It is recommended that, where Imagery Rescripting is not successful with clients, research methodology that is more suited to anecdotal research can be utilised to identify imagery approaches, which are tailormade for individuals whose presentation does not easily fit within an Imagery Rescripting methodology (Silver *et al*., 2010).

Current research studies for the treatment of BDD can be criticised for their lack of follow-up data. Whilst the client in this case study was not funded for any follow-up sessions, there were periods in her treatment when she experienced a significant gap in her treatments, for example, due to annual leave of the therapist, and also the time that she had to wait for her second block of therapy sessions to be funded.

Even though BDD is estimated to affect only 2.2% of the UK adolescent population, it is a debilitating and serious psychological problem having considerable impact to social and developmental functioning. It is the opinion of the authors that any contributions to the literature is to be encouraged. It is recommended that further research is done in this area.

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References

ARNTZ, A. & WEERTMAN, A. (1999). Treatment of childhood memories: Theory and practice. *Behaviour Research and Therapy*, 37 (8), pp. 715-740.

BRAUSER, D. (2011) Probability of Full Recovery from Body Dysmorphic Disorder. Good Over Time, Medscape (Online Journal).

BUHLMANN, U. & WILHELM, S. (2004). Cognitive factors in body dysmorphic disorder. *Psychiatric Annals*, 34 (12), pp. 922-926.

EHLERS, A. & CLARKE, D. M. (2008). Post Traumatic Stress Disorder: The development of effective psychological treatments. *Nordic Journal of Psychiatry*, 62, sup 47, pp. 11-18.

FERGUSON, C. J., MUNOZ, M. E., CONTRERAS, S. & VELASQUEZ, K. (2011). Mirror, mirror on the wall: Peer competition, television influences, and body image dissatisfaction. *Journal of Social and Clinical Psychology*, 30 (5), pp. 458-483.

GREENBERG, J. L., MARKOWITZ, S., PETRONKO, M. R., TAYLOR, C. E., WILHELM, S. & WILSON, G. T. (2010). Cognitive-behavioral therapy for adolescent body dysmorphic disorder. *Cognitive and Behavioral Practice*, 17 (3), pp. 248-258.

GROCHOLEWSKI, A., BUCKER, E., KASTEN,E., OSEN, B. (2018). Mental Images in Body Integrity Identity Disorder (BIID) and in Body Dysmorphic Disorder (BDD): An Exploratory Study. *Behaviour Change*, 35(3), pp. 174-184.

HARRISON, A., DE LA CRUZ, L. F., ENANDER, J., RADUA, J. & MATAIX-COLS, D. (2016). Cognitive behavioral therapy for body dysmorphic disorder: A systematic review and meta-analysis of randomized controlled trials. *Clinical Psychology Review*, 48, 43-51.

HOLMES, E. A., ARNTZ, A. & SMUCKER, M. R. (2007). Imagery Rescripting in Cognitive Behaviour Therapy: Images, treatment techniques and outcomes. *Journal of Behavior Therapy and Experimental Psychiatry*, 38 (4), pp. 297-305.

MORINA, N., LANCEE, J. & ARNTZ, A. (2017) Imagery rescripting as a clinical intervention for aversive memories: A Meta-analysis. *Journal of Behaviour Therapy and Experimental Psychiatry*, 55, 6-15.

PHILLIPS, K. A. (2007). Suicidality in body dysmorphic disorder. *Primary Psychiatry*, 14 (12), p. 58.

PHILLIPS, K. A. & HOLLANDER, E. (2008). Treating body dysmorphic disorder with medication: evidence, misconceptions, and a suggested approach. *Body Image*, 5 (1), pp. 13-27.

RITTER, V. & STANGIER, U. (2016). Seeing in the Mind's Eye: Imagery Rescripting for patients with body dysmorphic disorder: A single case series. *Journal of Behavior Therapy and Experimental Psychiatry*, 50, pp. 187-195.

SILVER, J. & REAVEY, P. (2010). "He's a good- looking chap ain't her?" Narrative and visualisations of self in body dysmorphic disorder. *Social Science & Medicine*, 70 (10), 1641-1647.

STOTT, R., WARREN, M., SALKOVSKIS, P., LAVENDER, A. & CARTWRIGHT-HATTON, S. (2012). *Oxford Guide to Metaphors in CBT: Building Cognitive Bridges.* Oxford: Oxford University Press.

VALINEJAD, C. (2015). Delivery Efficient Psychotherapy. *Clinical Psychology Forum, Special Edition: Lean*, p. 271.

VEALE, D., GLEDHILL, L. J., CHRISTODOULOU, P. & HODSOLL, J. (2016). Body dysmorphic disorder in different settings: A systematic review and estimated weighted prevalence. *Body Image*, 18, pp. 168-186.

WILHELM, S., PHILLIPS, K. A. & STEKETEE, G. (2013). *A cognitive-behavioral treatment manual for body dysmorphic disorder.* New York: Guilford.

WILLSON, R., VEALE, D. & FREESTON, M. (2016). Imagery Rescripting for body dysmorphic disorder: a multiple-baseline single-case experimental design. *Behavior Therapy*, 47 (2), pp. 248-261.

WITTE, T. K., DIDIE, E. R., MENARD, W. & PHILLIPS, K. A. (2012). The relationship between body dysmorphic disorder behaviors and the acquired capability for suicide. *Suicide and Life-Threatening Behavior*, 42 (3), pp. 318-331.

European Association of Psychotherapy Position Paper on the Nature and Policy Applications of Psychotherapy Research

Peter Schulthess

The European Association of Psychotherapy (EAP) was created to promote the independent profession of psychotherapy following the 1990 Strasbourg Declaration on Psychotherapy. [1] Its members are trained and expected to maintain the highest standards of clinical psychotherapy practice. As a leading European professional organisation and a member of the European Council of the Liberal Professions (CEPLIS), the EAP promotes professional best practices in the training of clinicians and in the practice of psychotherapy. To this end, the EAP encourages its members to participate in relevant psychotherapy research, and advocates the scientifically valid and ethical use of research findings in determining public policy regarding psychotherapy training and practice in Europe.

The EAP firmly supports the movement towards use of research in defining best practices in psychotherapy. However, the EAP maintains that psychotherapy must be recognised as a complex nonlinear psychological and psychosocial process in which many types of variables interact, such as the personal and professional attributes and assets of patients and therapists, the quality of relationships they form with one another, the relevance and impact of interventions used, and the support provided by their social networks and communities.

1. www.europsyche.org/about-eap/documents-activities/strasbourg-declaration-on-psychotherapy/

It is a basic tenet of all science that the research methods used to study a particular phenomenon should be relevant and applicable to the nature of that phenomenon. Whilst research based on natural science methodologies has provided considerable progress for the physical health and wellbeing of global populations, it is essential to recognize the differences in level of complexity between the psychological and psychosocial phenomena treated by psychotherapy and the biological phenomena treated by physical medicine. Success in medicine lies in having the correct treatment, correctly applied in treating the patient's pathology. By contrast, psychotherapists engage with patients as persons in a complex process of which specific treatment interventions ('techniques') form only one part, a part that been recurrently shown in large-scale, statistically controlled field studies not to be the most effective part of the treatment. Therefore, the EAP has strong concerns about the current tendency to view, as a single "gold standard" for research on psychotherapy, experimental methodologies that inappropriately replicate a pharmaco-medical model oversimplifying the complex process of therapeutic change dynamics and producing information that typically has limited external validity or applicability.

As has recently been observed in some countries, methodologically inappropriate empirical results are often taken up by policy makers who may not completely understand the nature and breadth of relevant research methods, but who nevertheless issue scientifically and ethically questionable guidelines for treatment of psychotherapy patients, as well as the training and qualifications of psychotherapists. The EAP believes that it is the responsibility of professional psychotherapy organisations and researchers to ensure that research findings are properly understood in context, and o correct potentially inappropriate or unethical training and practice guidelines derived from partially understood research principles. Accordingly, the EAP supports the use of a variety of suitable research methods and research designs that are attuned to the complexity of human experience and behaviour, and thus are broadly attuned to the nature of psychotherapy. We encourage research designs such as real-time monitoring of patient change in routine practice and in real-world eco- systems of clients that provide a reliable data base for understanding and modelling therapeutic change. We welcome practice-relevant methods that enable our members and their patients to participate in generating the kind of practice-based evidence that elucidates the lived experience of psychotherapy. The EAP considers research on best-practices in training and practice to be an essential part of the profession.

The importance of adapting research to meet the needs of its subject of study was clearly emphasized in the 2006 American Psychological Association Presidential Task Force Report on evidence-based practice in psychology, including the practice of psychological therapies. That document also pointed to the need for a methodological diversity that sufficiently considers the unique challenge of studying the complexity of human experience.

> *"Perhaps the central message of this task force report – and one of the most heartening aspectsof the process that led to it – is the consensus achieved among a diverse group of scientists, clinicians, and scientist–clinicians from multiple perspectives that Evidence-based practice and Practice-based evidence requires an appreciation of the*

value of multiple sources of scientific evidence". [2]

In this regard, the EAP encourages professionals who work for and with human beings in psychotherapy to adhere, as a guiding principle, to the idea that evidence-based practice should help patients attain a lasting improvement in overall quality of life, as well as providing short-term relief from distress and symptoms. For economists, this long-term focus on future wellbeing also holds a return on investment that is clearly appreciable.

The EAP's facilitation of research within its membership seeks to encompass, recognise, and integrate all aspects of research appropriate to psychotherapy. Researchers and clinical practitioners are invited to collaborate to produce research for professional practice and training that is both clinically relevant and externally valid. We further encourage mental health practitioner, researchers, and mental health policymakers to foster and rely on research that accurately reflects the nature of psychotherapy and the aspects of human experience it addresses. Doing so will allow real progress to be made in the provision of psychotherapy to the benefit of the recipients and the general public.

This document was prepared and submitted by the EAP Science and Research Committee Working Group: Lynne Rigaud, MSc Psych; Catalin Zaharia, MD; Dr. Heward Wilkinson; Prof. Gunter Schiepek; Prof. Mattias Desmeth; Peter Schulthess, MSc; Courtenay Young, Dip. Psych., and as external expert Prof. David Orlinsky – The document has been adopted by the General Board of EAP on March 13, 2021.

2. APA Presidential Task Force on Evidence-based Practice, p. 280. In: Evidence-based Practice in Psychology, pp. 271-285. May-June 2006. *American Psychologist*. Vol. 61, No. 4, 271-285. DOI: 10.1037/0003-066X.61.4.271

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EAP Statement on the Legal Position of Psychotherapy in Europe

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March 2021

1 The Strasbourg Declaration:

The basic position of the European Association for Psychotherapy (EAP) is enshrined in the 1990 Strasbourg Declaration on Psychotherapy, which states:

> *In accordance with the aims of the World Health Organisation (WHO), the non-discrimination accord valid within the framework of the European Union (EU) and intended for the European Economic Area (EEA), and the principle of freedom of movement of persons and services, the undersigned agree on the following points:*
>
> 1. *Psychotherapy is an independent scientific discipline, the practice of which represents an independent and free profession.*
> 2. *Training in psychotherapy takes place at an advanced, qualified and scientific level.*
> 3. *The multiplicity of psychotherapeutic methods is assured and guaranteed.*
> 4. *A full psychotherapeutic training covers theory, self-experience, and practice under supervision. Adequate knowledge of various psychotherapeutic processes is acquired.*
> 5. *Access to training is through various preliminary qualifications, in particular human and social sciences.*

2 The EAP's Definition of Psychotherapy

The EAP's (2003) definition of psychotherapy is, as follows:

1. The practice of psychotherapy is the comprehensive, conscious and planned treatment of psychosocial, psychosomatic and behavioural disturbances or states of suffering with scientific psychotherapeutic methods, through an interaction between one or more persons being treated, and one or more psychotherapists, with the aim of relieving disturbing attitudes to change, and to promote the maturation, development and health of the treated person. It requires both a general and a specific training/education.
2. The independent practice of psychotherapy consists of autonomous, responsible enactment of the capacities described in paragraph 1; independent of whether the activity is in free practice or institutional work.

3 Psychotherapy Training

The European Association for Psychotherapy has achieved a common and agreed standard for the training required to become a Psychotherapist across all its constituent 41 European countries. The EAP training standards are that the total duration of the education and training for the profession of Psychotherapist is at Master's level and must fulfil EQF Level 7. The length of the training must not be less than 3200 hours.

There are now two routes to achieve accreditation as a Psychotherapist:

- **Either** – spread over a minimum of seven years, with the first three years being the equivalent of a relevant University degree, and then four years which must be a training specific to Psychotherapy and at Masters EQF7 standard. The specialist training specific to Psychotherapy must contain all of the elements outlined by EAP which are required to become a Psychotherapist.
- **Or** – conduced as a five year full-time academic education and training in Psychotherapy organised by a University. This must be at Masters EQF7 level and contain specialist training specific to Psychotherapy. The training must include all the elements outlined by EAP which are required to become a Psychotherapist.

The training elements required by EAP are the academic study of the theory and practice of Psychotherapy; clinical practice (not less than 300 hours) under supervision (not less than 150 hours); professional skill development through studying training methodologies and their application; extensive and extended personal Psychotherapy; placement in a mental health setting or equivalent; Psychotherapy research and research methodology and technique, and the ability to critically evaluate research; diversity and equality training; safeguarding training and training in ethical professional codes and conduct.

Completion of training as a Psychotherapist can lead to the awarding of the EAP's European Certificate of Psychotherapy (ECP). The award of the ECP can be made when Psychotherapists can fulfil all the requirements laid out in §4 of the ECP document (here: https://www.europsyche.org/app/uploads/2019/05/ECP-document-version-7-0-voted-AGM-Vienna-Feb-2017_offic.pdf).

The EAP promotes the recognition of common standards of training throughout Europe, and tries to ensure the mobility of suitably qualified psychotherapists across member states.

The EAP is endeavouring to assist all of its European Accredited Psychotherapy Training institutes (EAPTIs) to identify their ECP courses in terms of the European Credit Transfer System (ECTS) and then to register them with the National Qualifications Framework office in their country at EQF Level-7 (Master's degree).

4 The Current Position:

In 2018 the EAP has adopted the 'Psychotherapy Act'. This is part of the process of the submission for a Common Training Framework for the profession of "Psychotherapist" to be agreed by the European Commission:

> The Psychotherapy Act encompasses all the professional actions, i.e. the autonomous, interdisciplinary, relationship-based and evidence-informed psychotherapeutic methods, for the treatment of psychological, psycho-social and psycho-somatic disorders and difficulties. A relationship of trust, empathy and confidentiality between the Psychotherapist and the client is essential for effective clinical practice. The Psychotherapy Act is underpinned by national and international ethical codes which respect the dignity, autonomy and uniqueness of all human beings. Psychotherapy is an independent profession from psychology, psychiatry and counselling. Psychotherapists usually have a first degree followed by a professional, highly specialized, theoretical and clinical training which includes research methodology and continuous professional development. The range of psychotherapeutic modalities is broad, and the profession is constantly evolving new developments in theory and clinical practice.
>
> (Adopted by the EAP Governing Board: April, 2018)

A Common Training Framework (CTF) is a legal tool to achieve automatic professional qualification recognition across EU countries, meaning that learning outcomes and professional competencies received in one European country are recognized throughout Europe. This is an extension of EU Directive 2013/55/EC about the recognition of professional qualifications.

The National Associations for Psychotherapy in nine of the countries (below) are now proposing the Psychotherapy Act as being the basis of a Common Training Framework (CTF) for Psychotherapy to the European Commission (see §3). These nine countries are: Austria, Belgium, Croatia, Germany, Ireland, Italy, Malta, Romania, Slovenia: and these nine countries meet the condition of at least one third of the current 27 European countries needed to establish a Common Training Framework.

At the time of writing, January 2021, the process of establishing the Common Training Framework for the profession of Psychotherapist is still being considered by the European Commission.

5 Legal Situation of Psychotherapy in different European countries:

The current legal situation with regards to psychotherapy in a number of European countries is very varied and is somewhat complicated. Countries in the EU are designated here by a *:

Albania: There is no regulation by law on psychotherapy. (2017)

***Austria:** Psychotherapy is an independent profession regulated by Austrian law since 1990 (Psychotherapy Act, 361st Federal Act of June 7, 1990 on the Exercise of Psychotherapy), which regulates the training, practice and exercise of professional psychotherapy, as well as the legal framework for the Psychotherapy Advisory Council („Psychotherapiebeirat"). The competent supervisory authority, the Federal Ministry of Health issues additional professional guidelines on a regular basis which ensures that not only the legal framework, but also the exercise of psychotherapy in practice comply to very high standards.

***Belgium:** In 2014, a law was voted that: defined psychotherapy; defined a general framework about training as being a post-graduate training of at least 70 ECTS over 4 years; recognised four main modalities; and established a Federal Council. In Sept. 2017, the Constitutional Court suspended part of the law and decided a delay on application of the law for existing psychotherapists.

***Bulgaria:** There is no legislation on psychotherapy, which is not covered or paid for by any health insurance. (2014)

***Czech Rep.:** The profession of psychotherapy is not regulated by law: only a qualification in psychology and psychiatry and a post-graduate specialization in psychotherapy is regulated, which includes a minimum of 5 years of practice in health care institutions, under supervision. There are about 10 approved modalities.

***Croatia:** There is a 'Psychotherapy Act' (2018) (here: https://www.europsyche.org/app/uploads/2019/10/ZakonPsihoterapijiENGLESKI.pdf) in Croatia that establishes psychotherapy as an independent profession, separate from psychology.

***Cyprus:** There is no law about psychotherapy and anyone can use the title "psychotherapist': there is a law regulating psychologists, some of whom claim to be psychotherapists. (2017)

***Denmark:** In Denmark, doctors and psychologists can be trained in psychotherapy as a part of their education and use psychotherapy in their work with patients. Otherwise, psychotherapy is not a part of the Danish public healthcare system.

***Estonia:** There is currently no law about psychotherapy in Estonia. There is a predominance of biological treatment methods and psychiatric services. The availability of psychotherapy, counselling or help for emergency situations is very limited.

***Finland:** In Finland, there is a 1994 regulation about using the title of "psychotherapist". Psychotherapy training programmes are multi-professional, but all training is either in psychological or psychiatric institutions in universities.

***France:** In France, since 2010, the title "psychotherapist" has been restricted to a register consisting of medical doctors, psychologists and/or psychoanalysts. The practice of psychotherapy is not regulated by law.

***Germany:** In 1999, a 'Psychotherapists' law was passed which made a psychotherapist a licenced health profession with similar rights and duties as physicians, but restricted the prescribing of medication or other medical interventions. A psychotherapist is required to have a substantive post-graduate training. There is a Chamber of Psychotherapists that regulates and monitors their professional competencies and decides which approaches are scientifically valid. There are a huge number of non-licenced psychotherapists that have a legal permission to treat patients under a "health practitioner" licence. Law reform was planned by the Ministry of Health in 2017.

***Greece:** There is no legislation concerning psychotherapy: it is not recognised as an autonomous profession and the title of "psychotherapist" is not legally protected. (2014)

***Hungary:** Psychotherapy is defined by the Health Act CLIV 1997, which recognised 16 accredited psychotherapeutic methods. It can only be practiced by a specialised physician or clinical psychologist with a specialised qualification in psychotherapy, which thus has a post-graduate level of entry and three years of training.

***Ireland:** There is no law referring to psychotherapy in the Republic of Ireland. The professions of counselling and psychotherapy are currently self-regulated by a number of professional bodies, though the Quality & Qualifications Ireland (QQI) responsible for maintaining the National Framework of Qualifications now require minimum standards. There are Governmental plans to regulate these two professions. (2016)

***Italy:** Italian Law (1982, #162) establishes that psychotherapy can only be practiced after a specific 4-year post-graduate training, with entry only via a medical or psychology degree. Training is the prerogative of universities or recognised private institutes (Law: 1998, #509). All psychotherapy approaches are recognised.

***Latvia:** There are 'Psychotherapist's Speciality Regulations' issued by the Latvian Welfare Ministry in 2002, that defines psychotherapy as a primary medical speciality of a psychodynamic psychiatrist and doctor in psychosomatic medicine, who provides aetiologies, pathogenesis, diagnosis, treatment, prevention and rehabilitation, based on an integrative biopsychosocial approach. Interestingly, the 'psychotherapy' title and practice in the private sector is not regulated by law.

***Lithuania:** Currently, there are no psychology or psychotherapy laws in Lithuania, thus, 'psychologist' or 'psychotherapist' are not protected titles. The title of "medical psychologist" is regulated by the Ministry of Health: Medical psychologist is a psychologist, who graduated from university with a master degree in clin-

ical or health psychology, who has a professional seal with professional number provided by the state accreditation body and who is practicing in a health care institution which also is licensed to provide personal health care services. Medical psychologists work in various mental health care setting including primary care, psychiatric hospitals, rehabilitation facilities, etc.

*__Luxembourg:__ There was a 2015 psychotherapy law passed, under which all practitioners must have a Master's degree in psychology or psychotherapy, or an equivalent medical training certificate. In principle, all psychotherapy patients can get reimbursed.

__Kosovo:__ The profession of "Psychotherapy" in Kosovo is not regulated by law and no public institutions have any legal status for psychotherapy. This means that is not forbidden to use the title of psychotherapist, nor to train, nor to provide services. (2014)

*__Malta:__ There is a new law in Malta, voted in 2018, that regulate psychotherapist in a similar fashion to the Austrian law.

*__Netherlands:__ There is a restrictive law on psychotherapy, with an entrance level as well as the modality-training defined by governmental bodies. Only psychologists, psychiatrists and medical doctors can start a modality-training in Cognitive-Behavioural Therapy and then enter a national register. All other modalities are called 'alternative' therapies and are not accepted. It is even prohibited to use the word 'psychotherapist'. (2017)

__Norway:__ There is no specific law on psychotherapy or psychotherapists, but the law for practitioners of alternative treatments apply. (2014)

*__Poland:__ There is no law and no national register of psychotherapists. Every 2 years, the Ministry of Health issues various decrees that limit the certification of psychotherapists to psychologists and doctors. There are a large number of practising psychotherapists, but only about 25% are certified. There are an unknown number of untrained people claiming they perform psychotherapy, which include psychologists, addiction therapists, counsellors, medical doctors, esoteric therapists, etc. There is a consensus about psychotherapy training being at a 4-year, post-graduate level. (2014)

*__Portugal:__ In Portugal, psychotherapy is not regulated by any special law, though there are specific regulations for the provision of some health services, which may apply. The title of psychotherapist is not protected by law, but there are some efforts (possibly by psychologists and psychiatrists) to limit the title and apply restrictive training standards.

*__Romania:__ Psychologists are regulated by a Law 213/2004. Some can fulfil competency in the field of psychotherapy. There was a draft law, rejected in 2007, proposed psychotherapy as a profession. Currently, psychotherapy is considered as a specialisation of psychology. (2017)

Serbia: There is currently no legal regulation of Psychotherapy in Serbia. Since the Serbian professional organisation was formed in 1997 there have been several attempts to approach State bodies and Ministries. Associations of psychologists, psychiatrists, and social workers, Universities having Departments for Psychology, and other professional associations are all involved in discussing the legal regulation of Psychotherapy at a national level.

***Slovakia:** There is no currently no law about psychotherapy in Slovakia, nor any other form of legal regulation, so attempts were made to legitimise the practice of psychotherapy with the Ministry of Health, and these concluded in 2008. Psychotherapy can now only be practiced by people registered as healthcare professionals, which requires an appropriate degree and then professional training.

***Slovenia:** There is no law about psychotherapy in Slovenia, nor any other form of legal regulation. There have been several attempts to regulate the profession, but currently 3 professional associations provide some structure. (2017)

***Spain:** There is no law in Spain that recognises psychotherapy as a profession. There are attempts to legalise psychotherapists, but only if they are psychologists. EFPA's (Spanish Psychotherapists Association) recognise people with EAP's European Certificate of Psychotherapy. (2017)

***Sweden:** To become a licensed psychotherapist in Sweden, you need firstly 5 years of both practical and theoretical education as a psychologist, and then one year of supervised practice. (2019)

Switzerland: A Federal Law about Psychology Professions (PsyG) was introduced in 2013. All students who want to follow postgraduate training in psychotherapy have to pass a master degree in psychology at an accredited Swiss high school or university. As a consequence, all institutions licensed to offer postgraduate training have to have their curricula accredited, according to the PsyG quality standards. The accreditation process was finalised in 2019 and has to be repeated every seven years. Psychotherapists – whether independent or employed – are only allowed to treat by prescription or by delegation, mandated by a medical doctor. Only psychotherapists who have completed the above training are licensed to use the title "Federally Approved Psychotherapist" and only this title allows them to practice independently; permission has to be issued by the cantonal departments of health.

United Kingdom: Since 2010, there has been an Accredited Voluntary Register for Psychotherapists, which is accredited by the Professional Standards Authority (PSA). The PSA is itself authorised by the Governmental Privy Council. There are many modalities of psychotherapy recognised. Qualification requires the completion of 4-years of training at Masters level. Following the political changes of Brexit (2020), the UK continues to be a full member of the European Association for Psychotherapy.

[Some of this information came from the Network for Psychotherapeutic Care in Europe (NPCE) (www.ncpe.eu).]

The conclusion is that – in some of these countries – there are, in effect, restrictive practices regarding who can access psychotherapy training and who can practice in psychotherapy. These practices can restrict the free movement of labour across the EU. There have been a few cases where psychotherapists, registered in one EU country with less restrictions, have been able to practice in another EU country with different restrictions, but this has usually meant going to court to establish that EU principles are superior to more restrictive national regulations.

Several countries have adopted a system whereby the Ministry of Health effectively determines who can practice psychotherapy in that country. This is significantly different from a 'legal right' to practice. There are also significant differences in many countries between psychotherapy in the health care system and the private practice of psychotherapy.

Several countries have no laws or regulations, but most of these seem to be moving to some form of registration. There is a significant difference between 'registration' as a qualified psychotherapist and the regulation of who can use the title of 'psychotherapist'. Therefore, there seems to be a need for a European-wide consensus.

6 The Professional Core Competencies of a European Psychotherapist:

In 2013, the EAP established the professional Core Competencies of a European Psychotherapist. These are available here: https://www.europsyche.org/app/uploads/2019/05/Final-Core-Competencies-v-3-3_July2013.pdf. These Core Competencies clearly establish a significant differentiation between the professions of a psychologist and a psychotherapist.

This differentiation has now been accepted by the European Skills, Competences, Qualifications and Occupations (ESCO), which identifies and categorises skills, competences, qualifications and occupations relevant for the EU labour market, education and training. ESCO is part of the Europe 2020 strategy, in that in the description of a psychotherapist (Code: 2634.2.4) it states (here: https://ec.europa.eu/esco/portal/occupation?uri=http%3A%2F%2Fdata.europa.eu%2Fesco%2Foccupation%2Faf69484e-b43f-4685-b22d-f3418df45c4d&conceptLanguage=en&full=true#&uri=http://data.europa.eu/esco/occupation/af69484e-b43f-4685-b22d-f3418df45c4d):

> Psychotherapists assist and treat healthcare users with varying degrees of psychological, psychosocial, or psychosomatic behavioural disorders and pathogenic conditions by means of psychotherapeutic methods. They promote personal development and well-being and provide advice on improving relationships, capabilities, and problem-solving techniques. They use science-based psychotherapeutic methods such as behavioural therapy, existential analysis and logotherapy, psychoanalysis or systemic family therapy in order to guide the patients in their development and help them search for appropriate solutions to their problems. Psychotherapists are not required to have academic degrees in psychology or a medical qualification in psychiatry. It is an independent occupation from psychology, psychiatry, and counselling.

The alternative labels (sub-categories) of 'psychotherapist' include:

> neuro-linguistic psychotherapist; geriatric psychotherapist; psychotherapy practitioner; person-centred psychotherapist; humanistic psychotherapist; youth psychotherapist; systemic therapist; body psychotherapist; hypno-psychotherapist; group psychotherapist;

existential psychotherapist; reality therapy psychotherapist; transactional analytic psychotherapist; cognitive behavioural therapist; specialist psychotherapist; person-centred psychotherapist; integrative psychotherapist; positive psychotherapist; transpersonal psychotherapist; gestalt psychotherapist; psychodynamic psychotherapist; psychoanalytical psychotherapist; multi-modal psychotherapist; child psychotherapist; psychotherapy expert; practitioner of psychotherapy; expert psychotherapist; expert in psychotherapy; psychodrama psychotherapist.

7 The European Council of the Liberal Professions (CEPLIS):

The European Council of the Liberal Professions (CEPLIS) (www.ceplis.org) is the only inter-professional association bringing together the various liberal professions at the European Community level. All of its members are national inter-professional and European mono-professional bodies representative of the various sectors. The EAP is recognised as a mono-professional member: so is the European Federation of Psychologists Associations (EFPA).

CEPLIS can only take a position on a specific problem concerning a given liberal profession on the express request of the member representing this profession within CEPLIS and exclusively within the limits defined by its association objectives. Moreover, CEPLIS shall not take sides in any conflict involving different professions represented by it, different representations of the same profession at the European level, or different Interprofessional Organisations within any one State. Each member of CEPLIS maintains the right to defend itself the special interests of its profession within Europe.

This Council therefore establishes a clear structure that can help to maintain the differentiation and the independence between the two parallel professions of psychotherapy and psychology.

8 A European Professional Card (EPC) & the Europass:

The European Professional Card (EPC) only works for regulated professions and is thus only currently available for some professions (general care nurses, physiotherapists, pharmacists, real estate agents, engineers, and mountain guides). It clarifies the qualifications of a professional and thus acts as a sort of professional passport.

This EPC system may be extended to other professions, or they may choose to adopt a similar system (maybe something like a 'Europass'), which helps to communicate a professional's skills and qualifications and thus assists their mobility of learning and labour.

9 EFPA & EAP

The European Federation of Psychologists Associations (EFPA), which represents European psychologists, is developing a 'EuroPsy' (a European Certificate in Psychology) that establishes a European standard of education and professional training in psychology. It may be worth noting that a "EuroPsy Specialist Certificate in Psychotherapy" can be issued to a psychologist, with more advanced training in this specialist area of psychotherapy.

The EAP may well develop a 'EuroPsych' (based on the European Certificate in Psychotherapy), as a way of identifying the professional training and qualifications of a European psychotherapist.

These are practical methods of both differentiating, and also identifying, the professional training and qualifications of members of these two parallel professions.

10 Differences between European Psychotherapy and European Counselling:

Whilst there are some obvious similarities between these two professional activities, there are also considerable differences. Firstly, counselling is often not present as a significant professional activity in a number of European countries. There is a European Association for Counselling (www.eac.eu.com) and there are a number of articles available that differentiate between the two professions.

In academic terms, a counselling training is often set at a Certificate (1-year: EQF-4) or a Diploma level (2-years of tertiary education: EQF-5), though there are also some professional 3-year and 4-year trainings, as well as degree-level trainings (EQF-6). Entry into a full professional counselling training is usually not set at a post-graduate level.

While there are various different forms (methods) of counselling, it seems to be somewhat more multi-disciplinary than psychotherapy, where there are many very clearly defined different modalities (see §5). The professional core competencies of a European Counsellor (see here: https://eac.eu.com/standards-ethics/core-competencies-2/) are significantly different from the (previously mentioned) professional Core Competencies of a European Psychotherapist (see here: https://www.europsyche.org/app/uploads/2019/05/Final-Core-Competencies-v-3-3_July2013.pdf).

There are also several intermediate positions in different countries like: "counselling psychologist", "psychological counselling", "psychotherapeutic counselling", etc. and some professional associations (like the British Association for Counselling & Psychotherapy) do not differentiate between these two professions.

IN MEMORIAM

MONY ELKAÏM

7 November 1941 – 20 November 2020

Dear Friends, dear Colleagues,

Some very sad news has arrived – our dear friend and colleague, teacher, founding member and former President and an Honorary President of EAP, Professor Mony Elkaïm died in Brussels on 20th of November.

He made enormous contributions to EAP with his energy, wisdom, political talent and humour in calm and turbulent times of our existence. He always approached people very personally, with an open heart, inviting EAP Board members to his home in Brussels, when we have had EAP meetings in his town. His talent to find a peaceful and balanced solution in most difficult situations was legendary, indeed.

Many of us consider Mony Elkaïm to be an exemplary psychotherapist, and as a excellent personality to follow. He will live forever in the hearts of those who knew him.

Rest in peace, dear friend and teacher!

Condolences to his wonderful family from all of us.

Eugenijus Laurinaitis
EAP General Secretary

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To all those who knew him, Mony leaves the memory of a man with exceptional charisma, of a brilliant theorist, of an extraordinary therapist with unique intelligence and intuitions. He was a pioneer of family therapy, which he helped introduce in Europe.

After training in neuropsychiatry at the Université Libre de Bruxelles (ULB, Brussels) and a stay in the United States, upon returning to Belgium he created in 1979 in Brussels the Institute of Family and Human Systems Studies with which he organized the first major international family therapy congresses in Europe in 1981, 1983, 1986 and 1989, to which were invited the American and European pioneers of family therapy as well as representatives of antipsychiatry (whose net-

work he had coordinated in the 1970s). These congresses served as models for those subsequently organized by EFTA.

After coordinating (with Maurizio Andolfi) the European network of family therapists, he was at the origin of the foundation of EFTA which he chaired for many years until. After the subdivision of EFTA in 3 chambers, he became chair of the chamber of Training Institutes (EFTA-Tic). Mony was always concerned with defending the status of European family therapists.

In 1979, he also created the first French-speaking family therapy journal – the "Cahiers Critiques de Thérapie Familiale et de Pratique de Réseaux" – which published both translations of the American texts of the pioneers in our field and articles testifying to the development of these practices in European countries.

Mony Elkaïm was an outstanding, internationally recognized trainer in systemic family therapy, stimulating the deployment of the sensitivity and skills of the many therapists he trained and supervised around the world.

Edith Goldbeter
Head of Training, Institut d'Etudes de la Famille et des Systèmes Humains, Brussels.

■ ■ ■

With sadness and admiration, I remember Mony and keep him in my Heart as a Friend forever.

Alfred Pritz
Former EAP General Secretary

■ ■ ■

I am so sorry to hear of Mony's passing (Nov. 20th). I somehow thought of him as eternal. In any case, his memory is eternal. Although it has been a few years since I attended meetings of the EAP, where I got to see you all, I remember Mony as if it were yesterday.

His personality really marked me: not just as a gracious humanist, but also as an authentic author (I loved his book, *"Si tu m'aimes, ne m'aime pas"*), and as EAP president, cumulating personal authority with an empathetic ear for all, but especially his ever-present smile and the eyes that went with it.

Mony was also a great dancer, as I learned in a Latin Quarter nightclub "Cave" when the EAP met in Paris. That actually inspired me to take up lessons, and since then dance has become a major hobby for me, thanks to

Mony! He was fun-loving, yet somehow found time in an incredibly busy schedule to discover new things and places, like the 'Procope' restaurant, with a small handful of EAP buddies during that same weekend in Paris.

So much more could be said, but these are the first memories that come to mind on hearing of his passing.

Joanne Graham Wilson
Member of IJP International Advisory Board

■ ■ ■

I worked with Mony within the EAP for many years: it was a total delight: – we really bonded, or, at least, he made me feel that we did –possibly he did that with everyone. He used to stand up in meetings whenever there was any contentious stuff going on and say, with his great beaming smile on his lovely face: *"Dear Friends, Dear Colleagues…"* – and the atmosphere changed like magic. He was a magician!

Together, in the early days of EAP, one of the contentions was around how the power was distributed amongst the various committees. Eventually, we pushed for and established the European-Wide Organisations Committee (EWOC) during some of the EAP meetings in Rome, in about 1997. This created a necessary balance, along with the National Umbrella Organisations Committee (NUOC), so that associations and organisations representing a method or modality of psychotherapy had their own place of equality within the EAP structure, in parallel with the National Associations. We used to say that the NAs provided the quantitative check and the EWOs provided the qualitative check. He chaired this EWO committee for many years.

Another contention in those days was that it seemed as if everyone was over-involved in the early debates within the Training Standards Committee and that these discussions were superseding the rest of the business of the Governing Board. The 'solution' was to clarify what was called the "ECP Document", so, at his intervention, about 4 of us met at Mony's beautiful home in Brussels for one weekend, in between the EAP meetings, and we went through the ECP document with a toothcomb and made about 100 amendments to it: it then it passed through the next TSC & Board meeting easily – with everyone being somewhat overwhelmed – and the size of the TSC was then reduced dramatically. I am totally convinced that this could not have happened without Mony's intervention and endorsement: he was excellent as a powerful 'influencer' – possibly working best from behind the scenes. However, it was, to everyone's great delight, that he was – eventually – elected as President and then Honorary President of the EAP in 2009.

He resonated – he radiated – an atmosphere of equanimity, luxury, expansion, and friendliness. He was truly a "giant" within the organization, irrespective of his size. We were aware of his prodigious output, especially within systemic Family Therapy; of his Belgium-Moroccan background; of his somewhat radical "anti-psychiatry" endeavours, especially in the 1970s; but none of these seem to matter when with him, one was dazzled by his warmth and charm.

Courtenay Young
Editor, IJP

This is sad news indeed. He was an inspiration to so many – both inside the EAP and outside. Many of us owe him a great deal for his personal friendship and support. Behind that was a rich and extensive life, experienced in depths and well-lived. May he rest in peace.

Adrian M. Rhodes,
Past President, EAP

▪ ▪ ▪

I feel so sad to hear this news. Mony and I co-chaired the EWOC and GAP for many years. He was potent and caring: a prince of generosity! It is a great loss for all of us who had the privilege to work with him. Thanks, dear Eugenijus, for your authentic message.

Isabelle Crespelle

▪ ▪ ▪

Dear Colleagues,

We all know that, at one moment, there is a time to go beyond. Mony Elkaïm will remain within me as long as I live, and if possible beyond. A true person of human values and more. Thank you, Mony.

Paul Boyesen
Past President of EAP

▪ ▪ ▪

I am deeply saddened to hear of the death of Mony. When I first arrived in EAP in the late 1990s, he was so warm towards me and helped me understand many things about our organisation. It is so sad to lose a founding member and former President and Honorary President of EAP. His wisdom, diplomacy, warmth and stature have helped to enable the growth of EAP. Rest in peace, Mony!

With warm wishes, especially to all dear colleagues who mourn his loss,

Patricia Hunt
President Elect of the European Association for Psychotherapy

We offer our condolences to the family of Professor Mony Elkaïm. For the European Association of Psychotherapy, there is a great need to start writing its own history. Once again, I express my condolences on the great loss for all of us.

Oleksandr Filts and all Ukrainian colleagues
Ukrainian Umbrella Organization for Psychotherapy

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On behalf of the Professional Psychotherapeutic League of Russia, Prof. Victor Makarov and me personally. I would like to share our deepest regrets for the loss of our dearest college, Mony, and to pass sincerest condolences to his family and friends.

Such a big loss for us all! With grief, Sofia Kamalova, PPL (NAO Russia)

▪ ▪ ▪

Mony was a great person and I have a beautiful memory of him. This is a great loss for European Psychotherapy. My deepest condolences to his family.

Patrizia Moselli (Italian NAO)

▪ ▪ ▪

A great loss! On behalf of the Latin American Federation of Psychotherapy, our sincere condolences and feelings. His contribution to psychotherapy will be unforgettable.

Emilia Afrange
Presidente da FLAPSI – Federação Latino-Americana de Psicoterapia

▪ ▪ ▪

Very sorry! He was a wonderful colleague! I remember him well.

Thomas Wenzel

Interview with Mony Elkaïm[1]

Ramona M. Covrig

Ramona Covrig: To which type of psychotherapy are you faithful in your practice? In which way is this type different than other psychotherapy practices, for example, a psychodynamic approach?

Mony Elkaïm: I practice Systemic Family Therapy. One of its concepts is 'resonance'. In order for you to understand it, let's suppose that, in therapy, I see a woman … and I might feel some rejection towards her. From a psychodynamic approach, we might try to understand the connection between the feeling of rejection and personal history: what kind of countertransference occurs. From a Systemic point of view, we could ask ourselves what – for the patient – is the function, the utility, the usefulness of this rejection. If we think this way, then maybe the woman is always rejected and, so, she becomes afraid of being accepted, because being accepted means for her, to take down her armor, to expose herself, and so maybe it's better for her to be rejected, so that she could still wear that armor and be safe.

That's why I might ask her whether she's popular in her family; if she thinks that she is a person that is always welcomed. And, if she tells me that she was always rejected, then I can check my hypothesis. My systemic understanding of resonance is of a concept in which the visible part of the iceberg is, or it could be a countertransference: the connection between how I feel and my personal history, and the invisible part of the iceberg, the systemic one, is the function of my feelings for the patient: their utility is for the human system that I am a part of. Let's analyze this now in terms of function; the symptom that occurs in the human system. If the patient is an anorexic girl, we could search not only for the connection between her problem and her past, but also what is the usefulness of her problem for the family. I've recently published a book with the results of Systemic Therapy, *"Systemic Family Therapy and Behavioral Therapy – for different types of pathologies"*. For example, with anorexia, the best approach for this is Systemic Family Therapy – and it's important to put the problem of anorexia as being from within the family.

RC: Is that similar to one of Adlerian principles about 'unacknowledged purposes'? Adler referred to this while wondering *"How does this symptom serve me?"*

1. This interview took place at Lindner Hotel, Vienna, during a series of EAP meetings in February 2010.

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ME: In many psychotherapeutic approaches you can find similarities, but – for Systemic Therapy – what is important is the function of a symptom in a certain context and that symptom helps the system to keep its homeostasis, its stability. So, the concept of resonance, that we have created, helps us to think of the system in psychodynamic terms and, at the same time, in systemic terms. Because someone's feelings are related to the past, but they are not reduced by it, and so they have a function in the therapeutic system that they occur in. When you feel something for someone, you should ask two questions: 'What is the connection between how I feel and my past?'; and 'What is the usefulness of the therapeutic system, for the human system, to feel how I feel?'.

RC: I recognize that teleological principle from Adlerian Psychology: How do you explain the term "transgenerational transmission"? Has it anything to do with the messages passed down from generation to generation?

ME: As a Systemic Therapist, I'm interested in transgenerational transmission because, with regards to secrets, for instance, even though the people, I don't know what the secret was at the beginning, the secret that has been passed down through generations. In my recent book called, "*How to Survive Your Own Family*", there is a chapter about secrets and how a secret can be transmitted from generation to generation. Although the secret itself got lost, the function of the secret is transmitted. It is very important to think along these same terms, from a Systemic point of view.

For instance, in the first chapter of the book that I mentioned before, we can see a mother who is very upset with her daughter. In fact, when she looks at her daughter, she sees her own mother projected in her and she tells the therapist: "*My daughter is just like my mother; the people that you love the most are the ones that reject you*". It's interesting how the issues between the patient and her mother have reappeared in the relationship between the daughter and her mother. What she doesn't realize is the fact that she is putting her daughter into her place, and that she is placing herself in the position of her mother, because the way her daughter is treating her is the same way that she treated her mother. When you can see a problem within a couple; or can see a problem in-between a parent and his child, it's interesting to ask yourself what is behind it. Maybe it is something that had its roots one generation before, not necessarily as a cause of what you feel, but it operates as a trigger of the present feelings.

RC: With reference to the book, "*How to Survive Your Own Family*", I have a question: '*Is being in a family like being in a trap, in most cases?*'

ME: A family is the best and the worst thing – both at the same time. A family can be the place that helps you, protects you and offers you love: a family can also be the context of hardship and difficulties. My task is to make the family (or the couple) therapeutic, which means helping each other. The individuals that have a problem come to the therapist and repeat what has happened to them inside their family, or the couple. This process allows the psychotherapist to initiate a new type of relationship that can then be exported into the family (or the couple) with issues. Psychotherapy is actually the ability of the therapist to help, not to repeat, what has happened in the family, but – now - experiencing something new. If, in a family or a couple, we have circular relationships, "revolving doors", in which each one member blames the other for the same thing, I tend to agree with everyone because my 'patient' is the relationship, not the individual. If we think in these terms of relationship, that allows us to get to the idea of a scenario, to understand what keeps peo-

ple locked inside the trap. So, the family or the couple are not the traps, but it is our self-written scenario that comes from a previous generation and makes us repeat these same roles. The psychotherapist enters into this scenario, and helps to change it, using resources that were unused before. My task is ... to help people liberate their resources, heal their relationships, modify the scenario ... in such a way that they can help each other, becoming a therapeutic family.

RC: As a therapist working with couples, I am glad to find that we think alike. How could people know whether it's better to follow a systemic psychotherapy, rather than a psychodynamic psychotherapy (like Psychoanalysis, Adlerian, Jungian)?

ME: In my book, *"The Understanding and Treatment of Psychological Disorders"*, I took all the categories from DSM-IV and asked psychiatrists, psychoanalysts, family therapists and behaviorists how they approach these symptoms, and then I processed the data statistically. The last chapter is called, *"What treatment do we use for a particular problem?"*.

With certain pathologies, Family Therapy is the best; in others, it is Behavioral Therapy; in others, Psychodynamic therapies are better. Statistically speaking, for some pathologies, certain therapeutic orientations are better. In general, when we are faced with a couple's issue (like, depression, eating disorder or addiction), Family Therapy works very well. With regards something like schizophrenia, Family Therapy can lead to a re-hospitalization – at the rate of 50%.

Statistics show us what approach works better. Systemic Therapy is useful for couples, when one of the members has depression; or for a family, when one of the children has a somatic problem or a drug addiction. Psychoanalysis functions very well in personality disorders.

RC: What is Narrative Therapy?

ME: Narrative Therapy is an approach developed by a friend, Kenneth Gergen, a sociologist by profession. The theory says that social interactions create narrations, and narrations create an identity. For instance, if I feel sick, this is maybe because of something that has been said about me, or something that I tell myself. Psychotherapy is a way to change my narrative, in order to make me feel different. The theory focusses on the role of language, and this is one of the characteristics that Family Therapy also has, close to what we call "social constructivism".

RC: Thank you very much for this interview!

ME: Thank you, my dear! (and he kisses me fatherly on the forehead, then 3 seconds later, proceeds to sing: *"Ramonaaaaa, Na, Na, Na!"*)

RAMONA COVRIG is a Romanian Adlerian Psychotherapist, Trainer & Supervisor; she is Vice-President of the Romanian Federation of Psychotherapy; Founder and President of the Institute for Adlerian Psychology and Psychotherapy; and an ECP & ECPP Holder and NASAP Diplomate.

The Lost Girls: Beyond the Shame and Guilt of Female Adult ADHD – Bridin McKenna

Bridin is a leading eating disorder clinician, obesity specialist, trainer, master trainer, speaker, consultant, advocate, and is Northern Ireland's only practicing holistic psychotherapist. Bridin founded and directs Life Therapies Clinic, Northern Ireland's first clinic treating obesity and eating disorders.

Date: 21st August Price: £110
Time: 11:30am – 6:30pm GMT (+1)

Sex Addiction: Myth or Reality? - Dr. Thaddeus Birchard

Dr Birchard is the founder of the Association for the Treatment of Sexual Addiction and Compulsivity (ATSAC) and a founding member of Recovery Programme in the UK. He created the first UK based therapeutic sexual addiction training programme for counsellors and psychotherapists and has trained many in the field.

Date: 19th September Price: £99
Time: 11:30am – 6:30pm GMT (+1)

Mental Wealth: How to Promote Mental and Financial Health & Resilience - Joyce Marter

Joyce is a psychotherapist, entrepreneur, author, and international speaker. She has helped millions take control and lead an abundant and joyful life. Marter is routinely consulted as a psychological expert in the media and has been featured in The Wall Street Journal, U.S. News & World Report, CNN and Fox News.

Date: 26th September Time: 2:00pm - 9.00pm GMT (+1) Price: £110

Single Session Therapy - Prof. Windy Dryden

A world-leading authority and author in Rational Emotive Behaviour Therapy. Professor Dryden is one of the leading practitioners and trainers in the UK in the Cognitive Behaviour Therapy (CBT) tradition of psychotherapy and in Single-Session Therapy (SST).

Date: 28th October Time: 11:30am – 6:30pm GMT (+1) Price: £99

Surmount Shame and Disarm Defense with DEFT (Dynamic Emotion Focused Therapy) - Susan Warshow

Susan Warshow is the founder of the DEFT Institute, which includes an ongoing training program in Dynamic Emotion Focused Therapy that is held monthly in Los Angeles. In addition, the Institute sponsors and participates in conferences, workshops, and lectures related to DEFT.

Date: 30th October Time: 4:00pm - 11:00pm GMT (+1) Price: £99

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Information and Guidelines for Authors

This is only an indication – a very small extract of the full and up-to-date **"Information and Guidelines for Authors"**, which is to be found on the IJP website: **www.ijp.org.uk** – please click on the **"Authors"** tab. Please ensure that you read all that information very carefully before submitting an article to the Journal

The **International Journal of Psychotherapy** welcomes original contributions from all parts of the world, on the basic understanding that their contents have not been published previously. (Previously published articles need a special permission from the IJP editors, and a clear reference and any appropriate permission from the previous publication). Articles should not have been submitted elsewhere for publication at the same time as submission to the IJP. Please ensure that articles are well written, with up-to-date references, and are in line with the highest standard of professionally published articles. **Research articles** will be subjected to special scrutiny.

Review Process: All manuscript submissions – except for short book reviews – will be anonymised and sent to at least 2 independent referees for 'blind' peer-reviews. Their reviews (also anonymised) will then be submitted back to the author, with recommendations from the Editor.

Manuscripts (or submissions) should be in the form of: either

- **Long articles**, which should not exceed 5000 words; or
- **Medium articles** (2000-3000 words); or
- **Short reports & reflections** or rapid publication (1000-1500 words); and
- **Book Reviews:** short (600-800 words) which are not peer-reviewed, or longer (800-1200 words) which will be peer-reviewed;
- **News Items** can be 100-500 words (not peer-reviewed).

In exceptional circumstances, longer articles (or variations on these guidelines) may be considered by the editors, however authors will need a specific approval from the Editors in advance of their submission. Word counts include Title, Abstracts and references. (We usually allow a 10%+/– margin of error on word counts.)

References: The author **must** list references alphabetically at the end of the article, or on a separate sheet(s), using a basic Harvard-APA Style. The list of references should refer only to those references that appear in the text e.g. (Fairbairn, 1941) or (Grostein, 1981; Ryle & Cowmeadow, 1992): literature reviews and wider bibliographies are not accepted. Details of the common Harvard-APA style can be sent to you on request or are available on various websites. In essence, the following format is used, with **exact** capitalisation, italics and punctuation. Here are three basic examples:

(1) For journal / periodical articles (titles of journals should **not** be abbreviated):
FAIRBAIRN, W. R. D. (1941). A revised psychopathology of the psychoses and neuro-psychoses. *International Journal of Psychoanalysis*, Vol. 22, pp. 250-279.

(2) For books:
GROSTEIN, J. (1981). *Splitting and projective identification*. New Jersey: Jason Aronson.

(3) For chapters within multi-authored books:
RYLE, A. & COWMEADOW, P. (1992). Cognitive-analytic Therapy (CAT). In: W. DRYDEN (Ed.), *Integrative and Eclectic Therapy: A handbook*, (pp. 75-89). Philadelphia: Open University Press.

Further Guidelines and Information for Authors and contact details are available on the IJP website: **www.ijp.org.uk** – see the "Authors" tab.

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