

Myths in Clinical Psychology: A Question of Credibility

Brendan Lloyd PhD, Psychologist in Private Clinical Practice, Byron Bay NSW

Abstract

New government initiatives in mental health have clearly relegated private practicing psychologists to the role of allied health professionals. These government policies devalue the role of psychologists as experts in psychology. These policies also short-change the consumers of mental health services in Australia. Arguably, there is no fair and free competition for consumers to make a choice between a medical treatment for a psychological problem and psychological treatment for a psychological problem. The medical profession supported by government policy makers has declared that psychological problems such as depression and anxiety are medical matters. In order to take our place in the market as private practitioners in mental health we are better off seeing ourselves as enemy health professionals. Unfortunately there is a myth amongst some psychologists that psychologists in private practice strengthen their position in the marketplace by presenting themselves as experts in brand-name psychotherapies such as CBT, IPT, EMDR, etc. Arguably, by subscribing to this myth psychologist run the risk of creating a credibility gap between their skills offered and fees charged. Psychologists can instead put themselves forward as experts in psychology. Psychotherapy delivered by psychologists can be based upon knowledge gained from research in psychology on topics such as stress, motivation, empathy, meaning, assimilation, and personality. Arguably, all these topics cut across all forms of brand-name psychotherapies. Instead of depending upon the credibility of a brand-name, psychologists can see themselves as strategic skills-based psychotherapists and experts in psychology.

Presentation

Australia has three National Mental Health Plans.¹ Plan-1 was conceived in 1993, Plan-2 in 1998, and Plan-3 in 2003. I first became aware of the National Mental Health Plans in 2001 during a one-year contract as the Mental Health Project Officer for the Tweed Valley Division of General Practice. My first introduction was when I read Plan-2 in around 2001. Can you imagine my delight as I read the plan so that I could discover the role of private practicing psychologists in mental health, in Australia, as we go into the new millennia?

Then can you imagine my disbelief when I discovered that the word “psychologist” or even the word “psychology” did not appear once in Plan-2. When I got Plan-2 onto my computer in the Acrobat format I did a text search for the words “psychology” or “psychologist”. My worst fears were confirmed, not one, less than one appearance of those words. I found one mention of psychiatrists in Plan-2, nurses were also mentioned once, and there were nine mentions of GPs.

I thought, surely this is a terrible mistake. How could it be that psychologists have no role in mental health in Australia? Then can you imagine my delight when Plan-3 became available. I eagerly downloaded the Acrobat version of Plan-3 onto my computer. I didn't bother reading it. I went straight to the search function, “Control-F”, and typed in the word “psychologist”. Wacko, I found two mentions. I couldn't help thinking that this was a big improvement on Plan-2. However in Plan-3 I found 15 mentions of psychiatrists 13 of these mentions refer to psychiatrists in private practice. There are 24 mentions of GPs in Plan-3.

The first mention of psychologists in Plan-3 is within the context of describing the workforce that provides mental health care. The implication in Plan-3 is that the mental health workforce has changed dramatically over the last 10 years and it now includes psychologists, and nurses, social workers, occupational therapists, and other allied health professionals. The second mention of psychologists in Plan-3 is in the context of providing the consumers of mental health services access to GPs, and allied health professionals.

¹ Second National Mental Health, National Mental Health Ministers July 1998
National Mental Health Plan 2003-2008, National Mental Health Ministers July 2003

Clearly GPs are seen as the main players in providing Australians with mental health care according to our National Mental Health Plan. In this respect I see no real difference between Plans One, Two, or Three. The only advance for psychologists in private practice is to be bundled into the category of “allied health professional” that includes people called counsellors.

As an example of GPs as the primary mental health carers, I have a brochure sponsored by the local Division of General Practice.² The brochure is titled “Visiting Your Doctor: What You Need to Know”. Inside the brochure there is an explanation for what a GP can do for you. A GP is a doctor who “looks at the whole person”, says the brochure. The brochure goes on to say, “This includes your mental health as well as your physical health”. The brochure continues to explain that “there is an endless list of what a GP can help you with and these include depression, drug and alcohol issues, eating disorders, relationship problems, sexuality issues, stress management.” Now hang on one second, isn’t this a list for what a psychologist can help you? Aren’t these psychological problems, not actually medical problems?

On TV last year, George Negus had a guest GP on his show, the George Negus Tonight show. It was on the ABC at six in the evening. On the night in question the GP was there to talk about depression. The message was clear. Depression is an illness. Depression is something that you need medical treatment for. And, the GP added, if you want counselling as well, then all you have to do is visit a particular web site and you can interact with a CBT computer program. There was no alternative view presented. There were no psychologists there on the show to present the non-medical point of view. And what is more the psychological help was devalued to counselling that can be delivered by a computer.

I found a booklet in a doctor’s surgery recently titled “Depression: What you should know.” The booklet is produced by Lundbeck Australia, an organisation that specialises in psychiatry and neurology. The booklet says that depression is due to a chemical imbalance and that you need to see your GP for proper treatment. The booklet does not mention that this is a “chemical imbalance theory”, not a “chemical imbalance fact”. But of course it is presented to the general public as a medical fact.

As a psychologist in full-time private practice I believe I know who my main competitors are. My main competitors are not my colleagues. My main competitors are the GPs, psychiatrists, drug companies, and people who call themselves counsellors.

I don’t know whether you have noticed or not but the medical profession, driven by the drug companies have taken over this thing they call Mental Health. The government of course supports and drives this thing called Mental Health. The term Mental Health is an undifferentiated term that includes all psychological problems and psychiatric issues. When I say psychological problems I mean depression, anxiety, panic, Posttraumatic Stress and Adjustment Disorders, addictive behaviours, personality disorders, etc.

I think that it is important to make the distinction between psychological problems and psychiatric issues. Psychiatric issues would be any acute hospital emergency situation involving suicide attempts, and acute anxiety and/or panic that is best dealt with by hospitalisation or sedation in the short-term. I would also of course defer to a psychiatrist on matters to do with bipolar depression, psychosis, and schizophrenia. Also you could say, if medication is required then it is psychiatric, or if psychotherapy is sufficient then it is psychological.

If we were to slice up the mental health pie about 80% of the population do not have mental health problems at all, and the remaining 20% do. If we further slice up the remaining 20% then about 5% of the population, to be generous, have what could be termed true psychiatric issues in the chronic or ongoing sense. The remaining 15% would best be seen as psychological problems. And of course, when I say psychological problems I do mean that these problems could otherwise be treated by a psychologist without drugs.

When it comes to treating purely psychological problems there is not one skerrick of evidence to show that medication is superior or more effective than any form of systematic psychological treatment (Kirsch, & Saperstein, 1998; Seligman, 1995; Schoenbaum, Sherbourne, Rubenstein, & Wells, 2001). It is purely a myth that psychotherapy and drug therapy together are superior to any one treatment alone (King, 1999). It is a myth that on average a drug treatment will speed up recovery if a

² Northern Rivers Division of General Practice, Lismore NSW, Phone 02 66 224453

person is engaged in psychotherapy (King, 1999). Surely psychologists can see themselves as the drug-free alternative to medical treatment for psychological problems. For that matter, should the consumers of treatments for psychological problems have a choice of one treatment or the other?

But of course consumers of mental health services in Australia do not really have a choice. There is no level playing field for competition. The government provides Medicare and Service Incentive Payments for GPs to treat psychological problems. Now there are various schemes to provide funding for access to allied health professionals. GPs control this funding. We are in competition with GPs we are not their allies. Psychologists should understand that we are not allied health professionals we are enemy health professionals.

I draw your attention to Martin Seligman's 1994 Consumer Report (Seligman, 1995). In America there is fair competition between psychologists and medical practitioners. In America there is a level playing field for consumers of mental health services. In America it seems that people are more likely to choose a psychologist than a drug treatment for their psychological problems. The consumer report also shows that psychologists provide a more sustainable outcome than a drug treatment.

Now why would this be the case? Why is it that someone who has suffered depression or anxiety would do better from psychotherapy in the long run than someone who has received a drug treatment? One reason is that generally people do not comply with drug treatments. In other words, there is a sizable proportion of the population who simply do not want to take drugs as an answer to their psychological problems. The other reason, and most compelling reason, is that psychotherapy provides people with skills for living. Or as I say it on my practice brochure, psychotherapy provides skills for wellbeing.

To sum up this part of my presentation, I am suggesting that psychologists in private practice are in direct competition with GPs in the area of treating psychological problems. As a result of the unfair competition the consumers of mental health services in Australia do not have a freedom of choice. The unfair competition is that a patient treated by a GP for a psychological problem is funded by the government, whereas the same person treated by a psychologist is expected to provide self-funding. Where there are government subsidies available to receive a treatment by a psychologist, these funds are controlled by GPs. Psychologists are told that they are allied health professionals. We are told that we do counselling. People who call themselves counsellors have the same status as psychologist under the new government funding initiative for access to allied health. In other words counselling is something that allied health professionals do to support the real treatment and the real treatment is the medical treatment.

How then do psychologists make their claim in the market-place? Let's look at it like this: psychiatrists have medications to distinguish them from other mental health practitioners. Seemingly long have gone the days when psychiatrists do psychotherapy. The social workers make their mark in the market place with Family Therapy. What are psychologists doing? Well it seems that the official APS line is that psychologists do something called CBT. This baffles me.

I ask this question with all sincerity. Should psychologists in private practice try to stake their claim in the market place based on brand-name psychotherapies such as CBT, IPT, EMDR, etc? Apply this question to any brand-name such as RET, SFBT, Gestalt therapy, etc. The argument is no. We should not put ourselves forward as experts in psychotherapeutic techniques we should put ourselves forward as experts in psychology as psychologists who treat psychological problems.

Anyone can do CBT or IPT or can learn to produce the correct behaviours for presenting any form of brand-name psychotherapy. Nurses can do CBT. Although social workers probably prefer family therapy, they too could do CBT. People called counsellors do CBT. For that matter it takes GPs only 20-hours to become experts in CBT or IPT under the new government initiatives in mental health.

It's not that CBT or IPT for example are not effective forms of psychotherapy. Chances are that either form of psychotherapy is about 80% effective on average for any client compared to the same client doing nothing. The problem is that both forms of psychotherapy are equally effective. To make this point even more clearly allow me to take you on a brief tour of history.

Remember Hans Eysenck? He was the famous and controversial psychologist that said things

like, “white people are smarter than black people”, “cancer causes smoking”, and in 1952 he said that “psychotherapy is no better than spontaneous remission” (Eysenck, 1952). In those days psychotherapy was synonymous with psychoanalysis or Rogerian Client Centred Therapy. But mainly it was psychiatrists involving people in four to six years of analysis. Eysenck researched hospital and insurance records and found that neurotics on average got better within two years without psychotherapy. Neurosis in those days meant depression, anxiety, panic, posttraumatic stress, etc.

Eysenck’s “spontaneous remission” bombshell set off an avalanche of research in psychotherapy over the 1950s, 60s, 70s, and 80s just to prove Eysenck wrong. This research reached a critical mass by the mid 1970s and two notable references appeared in the literature that cannot be ignored. These are Luborsky, Singer, and Luborsky (1975), and Smith and Glass (1977). Luborsky et al (1975) coined the term Dodo Bird’s verdict. The Dodo Bird’s verdict from *Alice in Wonderland* is “everyone has won and all must have prizes”. In other words all psychotherapeutic techniques are effective and they are all equally effective. Luborsky et al (1975) drew this conclusion from reviewing all the best research where two or more different psychotherapeutic techniques had been compared to each other in well constructed randomised control trials (RCTs).

Smith and Glass (1977) took a different approach and drew much the same conclusion. I believe that Smith and Glass (1977) can be credited with discovering the Meta Analysis where all the best research is gathered and the average effect-size is calculated. Smith and Glass (1977) reviewed something like 400 RCTs where a psychotherapeutic treatment was compared to doing nothing. The effect-size quantified the difference between being treated on average compared to not being treated on average. Smith and Glass (1977) concluded that on average there is an 80% advantage in being treated with psychotherapy over doing nothing. Smith and Glass (1977) confirmed the Dodo Bird’s verdict that all techniques create the same advantage over no treatment at all. Smith and Glass (1977) claim to have dispelled Eysenck’s spontaneous remission theory because by the mid 1970s analysis was fairly well outdated and most treatments by that time took less than six months.

The Dodo Bird’s verdict was further replicated in the early 1990s by a group of psychologists who referred to themselves as the Sheffield Group. These researchers headed up the Sheffield Psychotherapy Research Project. The main question was, is the Dodo Bird’s verdict really due to poor research designs?

The Sheffield Group projects involved a RCT where clients were randomly allocated to a CBT or an IPT treatment (Hardy, Shapiro, Stiles, & Barkham, 1998; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998). It was unnecessary to have a no-treatment control group because of the well established efficacy of either treatment. Then within each treatment condition there was a further random allocation to either an eight-session or sixteen-session treatment. All participants were screened. One of the main criteria was that each client was clinically depressed and not taking medication. Severity of the depression was also measured at pre-treatment and was an important independent variable in predicting outcome. So what happened?

There were two important findings from the Sheffield studies. First is that although the treatments were significantly successful, in the end there was no meaningful difference in the range of outcome measures for either CBT or IPT. The second result was that client’s with severe depression at pre-treatment did better in the sixteen-session condition for either CBT or IPT. Clearly Eysenck’s “spontaneous remission” theory is blown out of the water if a severely depressed person is able to show a significant improvement within sixteen-weeks without medication.

The Sheffield Group coined the term “equivalence paradox” (Shapiro, 1995). In other words, how is it that two different treatment-techniques with quite different stated sufficient and necessary conditions for change actually have the same effect? This is the Dodo Bird’s verdict come back to taunt us. The only conclusion can be that the technique *per se* is not of primary importance in psychotherapy. So you might begin to get an idea for why I have reservations about psychologists putting themselves forward as experts in any particular psychotherapeutic technique. Because, if I’ve noticed the folly of such claim to fame then for sure the policy makers in government have also noticed it.

And don’t think for one minute that it makes a difference having a psychologist delivering the CBT or IPT or any other brand-name psychotherapy. I wonder if you have heard of the Vanderbilt Study by Strupp and Hadley (1979). The Vanderbilt Study took a group of neurotic students and

randomly allocated them to one of two treatment-conditions. One condition was a treatment by trained psychotherapists and the other condition was the same number of sessions with university lecturers. The university lectures were in the Humanities, not psychology, and they were chosen because they were known as nice guys to talk to. The main finding of the study was that the outcomes were equivalent. This is a well known example of seminal research in psychotherapy. There is a sizable proportion of the psychotherapy research literature that asks the question of “who or what should do psychotherapy” (Christensen, & Jacobson, 1994)? Lay therapists for example have been compared to professionals and have been found to be equally effective. Social worker counselling has been directly compared to psychologists doing CBT in treating depression and found to be equally effective (King, 1999).

The idea that there is such a thing as a superior treatment-technique implies a drug-metaphor in psychotherapy (Stiles, & Shapiro, 1989). The drug-metaphor says that psychotherapeutic techniques contain specific active ingredients for change. The theory is that if the technique does not contain the sufficient and necessary active ingredients then it is an inferior technique. The Dodo Bird’s verdict come equivalence paradox should put the drug metaphor to rest. The specificity debate, however, raged on in the literature through the 1980s and it seems to rage on still with talk of validated treatments.

Perhaps one of the most impressive challenges to the specificity debate comes from Kazdin and Wilcoxon (1976) in their review of systematic desensitisation research. Desensitisation is very effective for treating circumscribed anxiety. During the 1970s there was a lot of excitement surrounding desensitisation. Much of the experimentation was around the question of specificity. In other words, which components of the process are necessary and sufficient for behaviour-change? Leading up to 1975, there is a list of impressive studies where desensitisation and its components were compared to cleverly devised placebo or pseudo treatments (Kazdin & Wilcoxon, 1976).

Kazdin and Wilcoxon (1976) concluded that the specificity assumptions for desensitisation are not sustainable in the face of the evidence. The argument is that when the variance for *credibility* and *expectation* is accounted for, there is an equivalent outcome for desensitisation and placebo.

In other words, if an entirely credible placebo treatment is delivered that creates equal expectations for change, then the placebo treatment will be as effective as the theoretically legitimate desensitisation treatment. Remember that a placebo in psychotherapy is merely a treatment that does not contain the *theoretical active ingredient*. In other words, social worker counselling would be a placebo from a CBT theoretical point of view.

To sum up this part of my presentation I am suggesting that psychologists in private practice run the risk of creating a credibility gap between services offered and fees charged if we make our claim to fame as experts in brand-name psychotherapies. This concern is based on what I see as a myth in clinical psychology that there is such a thing as a superior treatment in brand-names such as CBT or IPT as examples.

The challenge is to understand how contradictory rationales for psychological and behavioural change can be equally effective. This is the equivalence paradox (Shapiro, 1995).

Luborsky et al (1975) reasoned that if all psychotherapies are equally effective, then, they each provide an equally valid schematisation of the problem. In other words, each system of psychotherapy is just another way for clients to make sense of the world. The Sheffield Group draws much the same conclusion. The Sheffield Group articulates the common factors as *empathy* and *assimilation*. So although IPT and CBT are discernibly different in their stated necessary and sufficient conditions for change, ultimately the outcome is the process of assimilation.

The Sheffield Group says that we can shelve our psychotherapy treatment-manuals and return to research in psychology. For example, the idea of assimilation comes from the works of Piaget. The Sheffield Group further talks about the research by Carl Rogers, and the importance of an empathetic style to facilitate assimilation. The Sheffield Group also talks about the client’s personality, and needs, and the therapist’s responsiveness. These factors, assimilation, empathetic style, responsiveness, the client’s personalty and needs, cut across the theoretical boundaries of IPT and CBT as examples.

William Miller is a psychologist and a leader in the treatment of addictions through

Motivational Counselling. Miller (1998) says that what we have in all the various theories of psychotherapy is a collection of metaphors for change. The process of change, according to Miller (1998), is to be understood as meaning making, not in terms of applying techniques. One important feature of Motivational Counselling for addictions is to offer the client a menu of treatment-options, not to rigidly apply a treatment from a treatment-manual. Miller (1998) also stresses the importance of an empathetic style as opposed to the use of confrontation in treating addictions.

Miller's (1998) main topics of discussion are *motivation* and *meaning*. The Sheffield Group brings the focus to *empathy* and *assimilation*. Miller (1998) and The Sheffield Group converge on the one point along with others such as Neimeyer (1993, 1998), Polkinghorne (1995), Stiles (1988), etc. The point is that psychologist should do psychology, not grasp onto certainties found in treatment-manuals. Motivation, empathy, meaning, assimilation, and personality are valid areas of expertise for psychologists.

In my opinion what psychologists in private practice need is a unified psychological approach for claiming ground in the marketplace. We do not need to be competing against each other. We certainly don't need some psychologists calling themselves "clinical" and barring other psychologists from using the term who are otherwise in "clinical practice". We certainly don't need some psychologists trying to create an air of superiority based on their expertise in some brand name psychotherapy such as CBT.

Quite often when I mention these ideas to colleagues, I get a response something like this: "I don't just do CBT, I do whatever works". As a psychologist in private practice myself, I do sympathise with this response. Nevertheless I don't think that this is an adequate response because it sounds a bit wishy-washy. I have given this some thought because I too was saying the same thing when potential clients would phone me and ask me what I do. Now I say that I provide a strategic skills-based approach to helping people with psychological problems. If the potential client then asks "but do you do CBT", I say, "I'm not limited to CBT, it has its uses".

One such example of a strategic skills-based approach is the dialectical approach as devised by Marsha Linehan (1993a, 1993b). The Dialectal Behaviour Therapy might sound like a brand-name, but it is in fact a collection of strategies for being effective in helping people with Borderline Personality Disorder. As a guess, I'd say that the dialectal approach is probably a good collection of strategies for helping non-specific personality disorders with a variety of features, not just Borderline. The main strategy in the dialectic approach is to balance the validation versus change dilemma. This comes from the observation that people with borderline personality features are very easily invalidated by the process of change and that they often have a talent for self-invalidation.

A strategic approach firstly requires the psychologist to formulate how the psychological problem for any particular client functions. On this first point alone, this is where psychologists can make the primary distinction between themselves and medical practitioners. In other words, a medical practitioner sees the psychological problem as an illness, whereas a psychologist should be seeing the psychological problem as a symptom.

There are of course various techniques that a psychologist can implement to discover how a client's psychological problem functions. Listening and observing during the interview is one. Sometimes gathering a history can provide clues particularly if you begin to suspect a strong personality element in the problem. You could ask your client to complete Young's Schemas Questionnaire. You can set the client homework in the form of self-observation. Quite often I ask clients to acquire an exercise book and to log examples of the problem occurring during the week, on a day to day basis. In Solution Focused terms, this is a strategy designed to define the problem rule.

Another important strategy I use is to get the client to distinguish between stressors and stress. If there is a strong personality element in the client's problem, then I spend time on distinguishing stressors and distress. I don't know whether you have noticed how clients with a strong personality element in their problem want to spend a lot of time complaining about how bad it is for them. Sometimes the sessions can have a groundhog's day effect. In other words, every session can just be a repeat of the last session, filled with complaints about how bad things are. The strategy is to get a focus off the complaints and onto the stressors. Then the strategy is to provide the clients with skills to respond to the stressors.

The assumption that I am making in the strategic skills-based approach is that stress or distress

are both symptoms of a skills-deficit in dealing with stressors. Distress is seen as an exaggerated or more severe form of stress. Under the heading of stress I include the usual stress reaction symptom or suffering, but I also include anxiety, panic, depression, and the phrase I often hear, “I think that I’m going crazy”. Under the heading of distress I include impulsiveness, self-destructive behaviour and the quote, “some times I act crazy.” Under the heading of stressors I include demands, commitments, threats, danger, perceived or real, and chronic pain. Stressors of course can be overt environmental events or covert features in our personalities. Personality based stressors would include unrelenting standards, self-sacrificing, catastrophising, awfulising, entitlement, etc.

Once an individual client’s stressors are understood, then it becomes possible to introduce skills. Under the heading of skills I include a raft of cognitive, behavioural, and interpersonal tools such as observation, acceptance, letting go, meaning making, assertiveness, reframing, compartmentalising, meditation, relaxation, etc. Many of these skills are found in the brand-name therapies such as Mindfulness, CBT, IPT, Solutions Focused Therapy, etc.

I find that psychoeducation is an essential strategy in setting a foundation for my clients’ recovery from most psychological problems. The main tool I use is a story about the Lion and the Zebra. This story clarifies the distinction between stressor and stress. The story illustrates how stress can develop from stressors. But more importantly the story paths the way for an understanding of how to manage a stressor without experiencing stress. The moral of the story is that despite the fact that the zebra uses the flight or fight response to escape mortal peril, the zebra is not stressed by the experience. This story becomes a motivational possibility of living a stress-free life, like the zebra. The story illustrates that the key to a stress-free life is to *respond* to the stressors instead of reacting to them. The solution to the vast majority of psychological problems is to respond to stressors skilfully.

The point is that only a psychologist can do strategic skill-based psychotherapy in any kind of responsible way because it is doing psychology. GPs can’t do strategic skill-based psychotherapy because they are not educated and trained in psychology. Counsellors can’t do strategic skill-based psychotherapy because all they know about is counselling. Psychiatrists can’t do strategic skill-based psychotherapy because their speciality is drugs.

Conclusion

In conclusion, funding initiatives under the National Mental Health Plans provide the medical profession, mainly GPs, an unfair market advantage over psychologists for treating psychological problems. As a result the consumers of mental health services in Australia do not have a true freedom of choice for how they are treated. Psychologists are not projecting themselves onto the market place with credibility when they put themselves forward as experts in brand-name psychotherapies such as CBT or IPT. Anyone can do brand-name psychotherapies. GPs for example can become experts with only 20-hours of training. Psychologists in private practice need to claim the ground that is occupied by people with psychological problems. Psychologists need to clearly define the difference between psychiatry and psychology. Psychologists can do better than a medical treatment for psychological problems by providing a more sustainable outcome. Psychologists can do this through a united approach by presenting ourselves as experts in psychology for helping people with psychological problems.

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