
EDITORIAL: TAKING IT HOME WITH YOU

GREG JOHANSON

There is a sneaking suspicion running loose among mental health therapists that there are a certain number of people who are ready to be helped, and that any technique or method we use with them will basically do the job. Likewise, with people who are not ready, it doesn't matter what we do or how we do it. And, the folks who show up at seminars are probably the self-selected few who could grow using any method from primal scream, to being dangled over a snake pit, to doing an average New York City ten year psychoanalysis. So, don't be surprised if the stuff we learn at workshops falls flat on its face when we take it back home with us.

That's definitely a cynical, rather fatalistic, so-what's-the-use view. It is also highly dangerous to the financial well-being of places like the Hakomi Institute. Think of what would happen if students decided they could just as profitably spend their money on a vacation in the islands as on an in-depth, nuts and bolts hakomi training? Perish the thought! And after all the trouble we have gone through to put together what we consider a quality training.

But the thought doesn't perish easily. One of the most well researched, well documented, undisputed conclusions in the psychological literature today is that "Despite clear demonstrations by process researchers of systematic differences in therapists' techniques, most reviews of psychotherapy outcome research show little or no differential effectiveness of different psychotherapies." The few that do show a difference are suspect because they all confirm the therapeutic bias the researcher started out with. The verdict of the wretched, cursed Dodo bird judging the race in Alice's Adventures in Wonderland appears to hold: "Everyone has won and all must have prizes."

The Dodo Verdict is definitely unpopular with many clinicians who have put a life-time into cultivating a particular way of doing therapy, have attempted a number of

to date unsuccessful challenges to the validity of the verdict, and have total contempt for anyone who would suggest (even from research data) that people are equally helped by any therapist, any time, any place.

But, need this be such a big, bad bird? Isn't there something nice about the notion that "Everyone has won and all must have prizes?" It undercuts the dangerous assumption that one school must be right and all the rest wrong. It supports the more realistic assumption that we should be able to learn from each other as opposed to engaging in cut-throat competition. It contains the possibility of promoting community as diversely trained clinicians join together to search out what is best for the client as opposed to their representative schools of thought.

I am willing to dogmatically state that, as clinicians, we better, we ought, we should, put our heads together and pool the wisdom of our respective experiences. There is no cause for complacency in the consensus that psychotherapy is, as a matter of research fact, more effective than no treatment at all.²

Bernard Bloom, Professor of Psychology at the University of Colorado at Boulder, notes that the effectiveness rate of psychotherapy is about 75%. Not bad if we are talking about baseball batting averages. Bloom comments, however, that if he had a physical illness and a medical doctor said, "Don't worry. We have this great treatment that has a 75% chance of making you better, and only a 25% chance of making you worse than no treatment at all", that he would be inclined to respond as a patient, "That makes me wonder who is looking for a better alternative to this treatment."

Imagine having cancer. Does anyone think the medical establishment should tolerate complacency in simply putting money in the same old research ruts, and not ex-

ploring every new promising avenue, even if the new avenue does not follow the researcher's particular beginning bias?

Alfred North Whitehead used to counsel students to look at the common assumptions of various schools of thought that are not even conscious enough to be questioned. If we, as psychotherapists, were to look respectfully over each other's shoulders, my personal hunch is that we would discover that we do some of our best work by mistake. I think there is merit in proposals which argue for common mechanisms to various therapies that undergird and support the more obvious differences in technique. Bandura has argued that successful clients end up with a general sense of increasing confidence, efficacy, and control from a variety of therapeutic procedures. Others have pointed to the warmth, empathy, genuineness, support, and understanding that go into making a good therapeutic alliance. Some studies demonstrate that while beginning students in various schools of therapy show quite distinct ways of working, that senior, master therapists of different schools operate in ways much harder to distinguish.

In the May 1986 edition of The Harvard Medical School Mental Health Letter (Vol 2, Number 11), Jerome Frank points to a number of common features that enable therapies to help people. First, he makes the assumption that symptoms themselves are not so disturbing to people. While life confronts us with many predicaments, life is not a problem to be solved. People seek help when the symptoms are coupled with demoralization, a sense of being unable to cope, with accompanying feelings of poor self-esteem, confusion, alienation, and isolation. He then comments:

All psychotherapies attempt to combat demoralization by replacing confusion with clarity, and providing new concepts and information that enable the patient to make meaningful connections between symptoms and experiences that would otherwise be mysterious. All schools of psychotherapy, including those that use drugs, seek to help patients transform the meaning of their symptoms and problems, replacing despair with hope, feelings of incom-

petence with self-confidence, and isolation with rewarding personal relationships ... Even when therapy has little specific effect on symptoms, it can enable the patient to tolerate the symptoms by transforming their meanings. (p.4-5.)

All forms of psychotherapy have the following features that can be viewed as ways of directly or indirectly combating demoralization: first, a confiding relationship with a helping person; second, a setting identified in the patient's eyes as a place of healing; third, an explanation of the causes of the patient's symptoms; and fourth, a procedure for relieving the symptoms that requires active participation by both the patient and the therapist. (p. 5.)

All therapeutic rituals and procedures ... combat demoralization by strengthening the relationship between patient and therapist. It is a commonplace observation that among therapists with equal credentials and training, some are more effective than others. Apparently as yet ill-defined personal qualities contribute to the therapist's persuasiveness. (p. 5.)

Frank's comments offer a helpful perspective for how hakomi fits with the more general field of psychotherapy. He also goes on to comment on the general approaches of the four roughly-grouped categories of psychotherapy today: existential humanistic, dynamic (psychoanalytic), behavioral, and cognitive. His descriptions help make it clear that hakomi has borrowed from the wisdom of all these schools. We join with the existential humanists in seeking to offer "a totally open, non-defensive encounter in which the therapist strives to experience the patient's world as fully as possible." With psychoanalytic therapists we try to "bring underlying conflicts to consciousness." We agree with cognitive therapists that erroneous views of the world, which determine both experience and expression, can be accessed and identified; and with behaviorists that personality is a plastic, flexible medium, that new beliefs and behaviors can be rein-

forced and nurtured for increased satisfaction.

Work on identifying general, underlying mechanisms that apply across various therapies is helpful, I believe. Again, there is no license here for complacency. The care and goodwill of the therapist is fundamental and pre-requisite, but not enough. We need to strive for more precision in explaining the phenomenon of therapeutic change and how it can be encouraged. I think it is quite helpful that the general trend in psychotherapy research today is toward identifying and evaluating smaller sub-processes of therapeutic interactions, as opposed to evaluating entire therapies in relation to each other.

Here, I believe, hakomi can make a genuine contribution to the field, especially in our role as a training institute. Every time we do an in-depth training, the trainers revise the curriculum based on what they see happening with the end product students. What part of the theory or techniques are they not getting? What method seems to need a greater breakdown to make the parts explicit? What underlying assumption seems to be missing when the student employs a series of techniques?

The precision is likewise enhanced when students ask questions in the form, "I know you say to look for this when you do this, but what particular clues are you looking for?" Or students go out and practice and come back saying, "You know, I felt confident about the general direction I was going with people, but then when I realized such and such, a lot of the threads came together for me." Or, "The method just doesn't seem to work or address this situation."

Everyone involved in hakomi needs to share insights into the little clues that help make for precision and effectiveness in using the sub-processes of the work, so that we can communicate and pass them on to others in the field. Many can benefit from the results of our experience, and can integrate the results into their own practices though they might never engage in a full scale hakomi training. Certainly we need to voice the underlying principles of mindfulness and non-violence that promote the effectiveness of

processes such as accessing and deepening, or techniques such as contact, tracking, probes, etc.

It continually strikes me that psychotherapy as a modern art-science is very young, under a hundred years old for sure. That is cause for humility. And, we have wasted a lot of those years entrenched in opposing camps, throwing rocks at each other. We need, as Professor Bloom suggests, to be responsibly (not neurotically) bothered by our failures, as an impetus to growth and maturity; all of us. Likewise, Eugene Gendlin says we should pay exquisite attention to our successes with people. How did we and they, together, promote the healing transformation? And, I would add that we would do well to look again at the wisdom of the ages, even if it is 4,000 years old, and give up the presumption and grandiosity in thinking that we alone, in modern times, have got a handle on what it means to be human. I still remember a professor from college prefacing a course in the history of ancient thought by saying, "Now when we read these ancient texts, we are going to have to assume that these people were at least as smart as we are, if we are going to have any chance of benefiting from them."

Gendlin is my current, favorite "cloud by day and fire by night" guide for leading us therapists through the wilderness of psychotherapy research to the promised land of increased therapeutic effectiveness and precision, that can be both specified and used to predict outcome successes. In his paper "What Comes After Traditional Psychotherapy Research?"⁴ he lists eighteen suggestions for the re-directing of research in our time. I think they are worth listing, in brief, for the benefit of hakomi therapists in particular and other readers in general. Note that I am giving myself a large measure of editorial license in the way I phrase his own wording which makes his points less precise and formal. So, without blaming him for the folksiness of what follows, the gist of what he seems to be saying is:

1. Let's keep cassette and video tapes of our most clearly successful cases and send them to a central data bank that could build a profile of change measures, and what works, when, how, with whom, under what

conditions.

2. Let's not divide or rank our cases arbitrarily, but for learning purposes, compare the clearly good successful cases with the others, even if it is only two in relation to twentyfive.

3. Don't concentrate on predicting the differences between control and treatment groups; but more positively, that our treatment will increase the measure tested for the treatment group.

4. Don't assume that therapy is actually happening in a treatment group, but monitor the presence of actual therapeutic processes, and check the prediction that high process should differ in outcome from both low process, as well as control groups.

5. The results are inconclusive and unsatisfying from trying to use an entire psychotherapeutic approach as a research variable, because the unit is too large, global, diffuse, and diluted by elements held in common with other approaches. Let's look at more specific techniques or sub-processes within a single interview, and in other settings outside therapy. (But watch what probes you use when the pilot is landing the plane.)

7. Don't assume a technique or sub-process is uniformly well done in a treatment group, but monitor and define how it is done when effective.

8. Even within the research of sub-processes, as opposed to whole therapies, we would do well to specify micro-process variables. In terms of turning awareness inward through Gendlin's focusing, for example, it is necessary to differentiate a "gut feeling" (sad, glad, scared) from the "felt sense" of the as-yet-unclear referent. A different quality of attention and awareness is involved that can make or break the process.

9. Maintain a sharp distinction between measures of process (what we do) and outcome (what results happen.)

10. To encourage the most widespread use and adaptation of a sub-process, let's differentiate the form or style of our work

(doing gestalt chair reversal) from the substance of what we are attempting to encourage (sense two sides of a conflict and act out of the side usually experienced as alien) which might be encouraged through a number of forms, depending on the therapist's style of preference.

11. Let's go from prognosis, in terms of identifying individual traits that predict success or failure in therapy, to concentrating on how to change the process of therapy to make it more regularly successful for a greater number of people.

12. If available tests and measures for what we want to research (loneliness, sense of competence) don't address the precise aspect we are trying to get at, we will save a lot of time and useless energy by devising a new measure that does.

13. Let's get research, training, and practice closer together. In Gendlin's words: "When a process is specifically defined for research, the same specific can be used in training. Then it can be used again to assess the practice. The measures are separate, but the microspecifics are the same. Such specifics enable us to instruct paraprofessionals and laypersons. Research precision enables wider applications." (p. 134.)

14. The use and abuse of therapeutic micro-processes is not limited to strictly clinical settings. Society at large can and does incorporate various elements of therapeutic processes. Let's broaden research possibilities for studying micro-processes to anywhere they might be happening.

15. "The Old Strategy: Isolate Variables: Chemical vs. Psychological vs. Social. Replace It With: Control for all Three and Test Them Together. Body, psyche, and social interaction are three variables that we put together. They are already always together ... With different inter-actional conditions one gets different results ... We must not assume that the tested effects of one factor remains the same if one of the others is changed." (p. 135.) Honor the

unity principle. Everything is connected to everything else.

16. When different methods or variables are used together, such as chemotherapy and psychotherapy, or intra-psyche and interpersonal techniques, or stern parole officer and kindly family therapist approaches, we cannot assume they remain independent and unchanged. We must allow for the variable of their interaction, for "each to change the other so they find their natural unity." (p. 135.)

17. Let's not approach the various therapies as a whole and try to isolate out cognition vs. feeling vs. imagery vs. behavior. "In the human individual, they are already together! Everyone thinks, feels, dreams, and imagines; has a body; has a family; acts in situations; and interacts with others." (p. 135.) Let's study the therapies in terms of their different micro-processes which provide different accessing routes to the whole person, and allow the learning interaction of therapists being exposed to different methods to change the therapies.

18. Let's save heavy-duty, formal, time-consuming research methods for verifying hypotheses that have already been well explored and show promise of being significant. Let's spend the majority of our clinical research time "playing in the laboratory", tinkering, exploring a sub-process in common situations with friends, peers, students, clients, or a small number of research subjects. Here is where creative, informal curiosity, and fast feedback, disconfirming a hunch or opening up new leads, can put us on the trail of those good hypotheses that are worthy of more extensive research time and energy. And "let us also regularly write such exploratory ministudies, make them available, and discuss them." (p. 133.)

Here we arrive at the focus of this edition of the Forum. Contained within are a series of reports on how people played in the laboratory back home with hakomi in relation to such populations as cancer patients, anorectics, college students, horses (??), senior citizens, and the Spirit. They are all basically experiential-reflective pieces presented to both share and to stimulate further

exploration and discussion. As editor, I hope readers will both dialogue with the writers inside their own heads, and be inspired to "go thou and do likewise", sharing at some point their own experiences and reflections in writing. The editorial policy of this journal definitely allows and encourages this form of communication.

A couple of other research thoughts in closing: One. No amount of research and training will ever take the spontaneous element out of therapy. The principle of organicity teaches that every organic living system has a mind of its own, a self-directing, self-correcting quality that processes any input in a unique way. We will never be able to predict that this input will lead to this result, in this type of person, in this type of situation, every time - though this also does not imply any license to abandon the research trail of what processes seem to work in the best interests of clients most often. Every therapeutic response will necessarily retain an experimental quality. We will always have to track and notice what an individual does with an intervention, adjust, and go from there. And, there will always be the enormous complexity involved in putting two different living organic systems in the room together as therapist and client, and allowing for their unique interaction, as Gendlin suggests.

Second. There seems to be something going on that is not controlled by therapist and/or client. Growth happens in the face of ignorance, stumbling, and fumbling by therapist and client alike. Growth doesn't happen despite the most highly trained clinician employing the most state of the art techniques. M. Scott Peck is so impressed that growth happens at all, in the face of so many obstacles working against it, that he posits some spiritual force called grace to account for it in his book The Road Less Travelled. In hakomi, Ron Kurtz has often referred to the concept of negentropy as expounded by Bateson and Prigogine: the notion that there is a force in life that moves to build wholes out of parts, as well as the more well-known second law of thermodynamics, which posits the opposite. By any name, it seems that we are participating in something bigger than ourselves.

That would be a pretty tricky re- search variable to isolate. Still, I know from my own experience that therapy seems to go easier and more productively when I am aware of and honor, this reality of the unity principle at work. Perhaps someone could come up with an objective check-list that measures whether a therapist seems to be operating out of an engineering model that assumes a client needs to be fixed or rebuilt somehow, or a gardening-midwife model that assumes the therapist's task is more along the lines of providing the conditions that foster growth already wanting to happen, and helping the person to work through barriers to that growth. Then correlations could be made with the efficacy of the two approaches.

What other research topics are lurking in the bushes of the mind waiting to be noticed and explored by practitioners who may or may not have ever thought of themselves as researchers?

1. cf. "Are All Psychotherapies Equivalent?" by Stiles, Shapiro, and Elliot in the American Psychologist, February 1986, Vol 41, No 2., pp. 165-180.
2. cf. "Research in the Outcome of Psycho- therapy" by VandenBos, G. R. and Pino, C. D. in G. R. VandenBos (Ed.) Psychotherapy: Practice, Research, Policy, Sage, Beverly Hills, 1980, pp. 23-69.
3. cf. London, P., The Modes and Morals of Psychotherapy, Holt, Rinehard, and Win- ston, New York, 1964.
4. American Psychologist, February 1986, Vol 41, No 2, pp 131-136.

