

THE GENERAL VIEW OF PSYCHOTHERAPY / THE META MODEL AND PREDICTIVE / PREVENTATIVE MENTAL HEALTH CARE HAVE SEVEN GROUPS OF REASONS THAT AFFECT THE FOUR CORNERSTONES OF WELL-BEING

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Abstract

A common goal among the many schools of psychotherapy these days is to find elements of psychotherapy that apply to many of them. The basis for which a general view like this can be found consists at least of the language and terms used, discovery of new activities, the structure of therapy and the work environment. Since the realization of psychotherapy also attempts to prevent a patient's situation from worsening, the following question comes up: does the search for a psychotherapy metamodel feature elements that are similar to predictive mental health care? Mental health care in Finland employs a categorization of seven reasons and four cornerstones of well-being to prevent mental malaise, mental disorders, and negative exceptional behavior. This study collected a file of psychotherapeutic research results and compared it against a file regarding predictive mental health care, which affirmed the thesis "the general view of psychotherapy and preventative mental health care have a functional common categorization that consists of seven groups of reasons and four cornerstones".

KEYWORDS: *7x4-field, psychotherapy meta model, preventive mental work*

Introduction

Roman catholic culture has the following famous operating model: There is an unwritten rule in a village, according to which a citizen must go to a village priest several times each year to discuss their problems. The priest is trusted not to tell anyone about what has been talked about. After each session, the priest gives the person the following command: "For these sins, you must now say in silence the amount of Hail Mary prayers described by me and..." This model has been utilized for hundreds of years and it is still going strong in many places. It is used to treat mental malaise, psychic disorders, and negative exceptional behaviour without prescribing any chemical or biological medicine and without touching the body, but by assigning certain tasks and giving life advice. The priest doing the listening also receives valuable information about how the communities work to then produce well-being services. The history of such an old mode of operation is its own field of research. The following pieces, elements, parts, characteristics and other such can be identified in it:

- A) In the human relationship in question, both parties share common concepts, such as those of sin and mercy.
- B) The tradition always involves an agreed journey, where new actions, mode of behaviour or other equivalent answer, such as forgiveness or loving, are determined for the one seeking help.
- C) Both parties are clear on the structure of the operating mode. For example, a suitable place may have been arranged and the costs of the meeting have been covered.
- D) A certain atmosphere is present at the event, such as that of safety and confidentiality.

Current psychotherapeutic practice involves an enormous number of different schools and forms of therapy that experts have been laboriously trying to organize functionally. These days, patients seeking help may find their anxiety increasing from the trouble of finding the most suitable school of therapy for themselves. This results in the need to find a taxonomy, general view, metamodel or other equivalent for the forms of psychotherapy, which features as many schools as possible, and which can be used to study the effectiveness of psychotherapy.

Finnish culture utilizes predictive mental health care which focuses on alleviating the reasons for malaise and promoting desired behaviour using the so-called 7x4-field. The field features four cornerstones that affect the reasons for mental malaise, psychic disorders and negative exceptional behaviour that are organized into seven main categories (Heiska 2016). Since preventing the patient's situation from becoming worse is also central in psychotherapy, the following question comes up: Does the search for a psychotherapeutic metamodel feature elements that resemble predictive mental health care?

Problems

What kind of organization in producing psychotherapy allows success to be evaluated generally without committing to a specific school of therapy in advance?

What elements do the organization methods of psychotherapy and preventative mental health care have in common?

Methodology

Collecting a file of studies regarding success in psychotherapy and organizing the contents into suitable and functional classes.

Results

Observing the theoretical arguments, used techniques and their common parts underlying various forms of therapy revealed certain language conventions. This makes the search for conceptual clarity between various schools of therapy a central goal, even though its part in the search for functional general views in science can easily result in the following to be considered factual: The languages of various schools cannot be translated to fit all schools and simply cannot be understood (Heijenoort 1967). The following main categories – without Heijenoort's results about different languages, however – were determined while searching for procedures that would yield a functional general view of the practices of psychotherapy: A) Examination of the theoretical arguments underlying therapy. B) Examining the available techniques. C) Identifying common traits in various forms of therapy (Arkowitz 1992).

When examining the success of forms of psychotherapy addressing eating disorders, correlations with diminished symptoms are not enough. External evidence, clinical expertise and the patient's situational data must also be evaluated. Situational data shows e.g. that one's next of kin may use psychotherapeutic skills (Peterson et al. 2016). An example of these kinds of results can be traced as far back as the 1950s (Hohaus 1950).

Searching for common characteristics of psychotherapeutic procedures and seeking admittance into psychotherapy and comparing them with people seeking treatment for somatic issues revealed the following important difference: The majority of people seeking psychotherapy do not seem to seek help for their symptoms, but rather the feeling of confusion resulting from losing faith in themselves, their environment or other sensations of being lost (Wampold & Imel 2015). This phenomenon, called demoralization, has been known for a long time (Frank 1961). It is difficult to observe and account for in many practices though, since many symptoms, such as obsessive-compulsive symptoms, are very easy to notice and they impose labels on patients. In general practice, somatic examination, such as alleviating pain coming through one's senses, is also a clearer goal than the alleviation of mental malaise (de Figueiredo 2007). Ancient Greeks already had a concept of sin, which relates to demoralization and psychotherapy. It referred to actions pointed out by the main points told in conjunction. Sin can thus be defined using the following seven categories. Relevant research results can be found from modern times, such as the following related to the main points regarding sin:

- Anomie: Breaking laws, rules, and other orders (Durkheim 1897).
- Agnoema: A sin committed out of ignorance or accident, such as slipping, tripping, or saying something rude without realizing it (Hebrews 9:7 in the Bible), or equivalent offence (Meakin, J. 1997).
- Opheilima: Debts accrued because of negligence, breaking an agreement, lying or other such actions (Matthew 6:12 in the Bible, Geuras 1992).
- Hamartia: "Missing the mark" – when a person makes a mistake by meaning well but then notices the adverse effects of their actions and feels shame (Aristotle's poetics in 330–320 BCE & Fredriksen 2012).
- Parabasis: Crossing ethical boundaries, circumventing what is right or other such actions (De Man 1982).
- Paragon: Disobedience, negligence, and misinterpretation in regard to moral issues, etc. (Coggan 2020).
- Asebeia: Actions or lifestyles that produce evil (Leão 2012).

Many studies have observed how changes that occur during psychotherapy necessitate feeling and awareness, which leads to the deduction that all schools of therapy must use their own versions of self-awareness techniques regarding beliefs and attitudes that gradually lead to reorganization. A good example of this is how shame is processed (Guidano 1983 & 1991). The following finding has been found useful in processing shame in psychotherapy: The feeling of shame can be argued to enter a child's life as they are preparing to be held by another person. In other words, a child somehow prepares themselves in wanting to be held, which they perceive to feature mysterious micro-vibrations. If a child then feels they are being held by a strange and wrong person, they then feel and discover shame. Adults can benefit from this finding in examining their own emotions (Rechart & Ikonen 1994).

A so-called eye movement therapy (EMRD, or Eye Movement Reprocessing and Desensitization) has been developed for treating mental malaise following traumatic experiences. Part of this is a procedure, in which a psychotherapist swings a pen in front of the patient's eyes and asks them to track it with their eyes (Shapiro 1989). This treatment has proven successful and can be utilized in the teachings of various schools of therapy.

The following result was found when looking for similarities within the manifold schools of psychotherapy: Each psychotherapeutic theory features a principle called myth that is related to a ritual. For instance, the "therapy sofa", where the pain felt by the patient is explained, is the myth, and "the analysis of one's past" is the ritual (Morris 2003).

When looking for affecting elements from various psychotherapeutic treatments published by different schools of psychotherapy, it was discovered that treatments always include elements that complement the theory, but do not stem from it. These were categorized as follows: A) Unique and essential elements B) Essential but not unique elements C) allowed elements, and D) forbidden elements (Walz et al. 1993). An example of unique and essential elements are relaxation exercises developed as far back as the 1930s, and which are related to behavioural therapies (Jacobson 1938). Essential but not unique elements are e.g. a therapist's logical actions and the alliance, or adjacency, related to it (Flückiger et al. 2018). Allowed elements include procedures that various qualification boards for psychotherapist consider to be permitted parts of training and procedure. An example of forbidden elements is a form of therapy started in the late 1800s that treated hysteria in women. Upper class women in London frequently visited therapists who would caress their clitoris with their fingers to bring them to an orgasm. After this treatment became too stressful for therapists' fingers, electronic vibrators were developed. The form of treatment spread as a result of positive results but was eventually banned after being declared indecent (Granville 1883).

An examination of a therapy movement called NLP (Neuro-Linguistic Programming) that started in California in the 1970s has revealed serious problems regarding how the theory of various styles of learning lacks any scientific evidence conforming to current standards and how NLP has no common theoretical background (Lilienfeld et al. 2003 & Williams 2000). However, patients who have undergone mental image exercises as a part of NLP have frequently reported anecdotal success (Ojanen et al. 2004).

Studying the psychotherapeutic phenomenon of transference (a person having feelings in the present that seem to be unconsciously being redirected from the past) revealed that the results of interpreting transference depended on the structure of therapy relationships, one's perception of their current life situation at the time of seeking help, and demoralization.

When the processes of psychotherapy were studied in the 1960s, it was discovered that it is possible to develop computer software that allows a computer to ask questions from a patient related to mental disorder symptoms and then provide them with answers that end up resembling psychotherapy and yield results (Weizenbaum 1966). Artificial Intelligence was connected to psychotherapy by noticing this being related to the phenomenon of transference, which in turn is related to the Turing test (Turing 1950). In this test two characters ask and answer questions in writing, while a person who knows one of them is machine observes. After a time, the observer must say which one is the machine. If they are unable to tell, the machine has passed the Turing test. Some psychotherapy patients have found that a machine can feel distinctly like a human (D'Alfonso et al. 2017).

The primary finding of the review of studies comparing forms of psychotherapy showed that the success of therapy is best predicted with cooperative relationships between the patient and the therapist, as well as the patient's personal factors, such as their motivation towards the treatment (Laska 2012).

A comparison of psychotherapy monitoring studies showed that taking a five-year monitoring span and the patient's use of services after the therapy period into account yields significantly different results than looking at just the beginning and end situation of the therapy (Knekt et al. 2011).

A comparison of psychotherapeutic follow-up monitoring studies revealed that there many differences between forms of therapy regarding how much the patient's symptoms can be expected to recur after the treatment period. There are both primary changes in symptoms in the patient as well as secondary, or general benefits. A problem area in this case are situations where the form of treatment under scrutiny is suitable for one way of grade effectiveness, but not for others

(Crits-Christoph 2001).

Comparing different psychotherapeutic processes showed that therapists might work very differently from one patient to another and utilize methods from multiple schools of psychotherapy. Even in research setups based on group comparisons, the variables in the form of techniques got lost in the overall variation of data, leading to the following thesis: There are no effective forms of therapy, only effective therapists. The phenomenon was dubbed the equivalence paradox: no matter what you do, the end result is the same (Stiles et al. 1986). This confusing research problem was tackled with three kinds of specifications (Elkin et al. 1989) as follows:

- 1) Attempting to reduce the internal variation within study groups. If the group comparison methodology is to be retained, the quality of data must be improved from a statistical viewpoint. In other words, more of the same but handled better.
- 2) Attempting to understand the quality of the variance. Researchers noticed already in the 1950s that forms of psychotherapy may have more common factors than separating ones (Rogers 1957).
- 3) Questioning experimental group comparisons. The analogy of medicinal study contains methodological assumptions that may not correspond to the nature of the psychotherapeutic process. Clear-cut results can hardly be found if they are sought using tools that are irrelevant for the subject of study.

These were all examined in a large study, in which treatment processes were documented by recoding. The subjects of comparison were interpersonal therapy (IPT) and cognitive-behavioural therapy (CBT), as well as the groups of imipramine medication and placebo intervention with their usual treatment and follow-up visits. The result was that the secret psychotherapy in question is likely in the variation of content that currently known statistics do not account for (Elkin et al. 1989).

Studying various interpretations and practices regarding psychotherapy showed significant traits of pursuing political and financial gain, which also makes up one area of studying effectiveness (Laska 2012).

Deductions

Based on the described study, an organization, general view, metamodel or other such categorization that represents as many schools of psychotherapy as possible is formed thusly:

Psychotherapy features **four basic elements** that are specified into a functional form as follows:

A) The language used:

- * A common set of terms that allows those seeking help and therapists to understand each other.
- * Modes of expression with which the patient and therapist communicate with each other.
- * A common set of terms with which a therapist and other experts can discuss the treatment process.

B) Discovering new actions:

- * New modes of operation and associated new perceptions.
- * Discovering and utilizing new ideas that come about from treating the body.
- * Prioritization of goals, where the following metaphor is important: When a fire brigade arrives to put out a fire, what is their primary goal, dousing the flames or determining the cause of the fire?
- * Clarifying mental activity that leads to insights, reconceptualizations, findings and other such, as well as making it more understandable.

C) The structure of therapy:

- * Practices related to starting therapy.
- * Way of structuring a therapist's actions, and the used theoretical basis and idea of man.
- * The patients' insights and other changes in behaviour as a result of experience (learning).
- * A therapist's and a patient's meeting places, meeting situations, meeting times and the frequency of meetings.
- * Computer-assisted psychotherapy.
- * Managing the success of psychotherapeutic functions.
- * Accounting for the financial cost of psychotherapy in various forms of actualization.

D) The atmosphere:

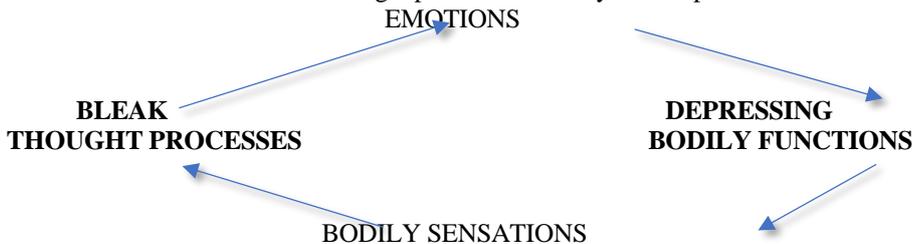
- * Values that are employed and met.
- * The limits of psychotherapy, categorized as follows: taking mental phenomena into account in social work – psychotherapy, physiotherapy – psychotherapy, taking mental phenomena into account alongside somatic treatment – psychotherapy and pastoral counselling – psychotherapy.
- * Processing the goals of psychotherapy.
- * The internal opportunities of progress of the patient and therapist.

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The **seven affecting elements of a psychotherapy** were specified as follows:

- 1) A respectful attitude toward the patient that meets them unconditionally: For instance, taking respect into account when interviewing the person for the first time. When processing a person's individual beliefs, the goal is to make them feel understood.
- 2) Empathizing with the other: For instance, processing customer transference, or the redirection of feelings towards a person. However, the essential visible functions of a psychotherapist are asking questions, nodding, reciting, leading relaxation exercises and such, as well as giving presentations on paper or on a computer screen and making statements.
- 3) Accounting for realities and limits: For example, the more debilitating the patient's depression or self-destructive urges seem to be, the more active the therapist will be. Situations that could be described as "you cannot tell a person who was born blind what the colour red truly is" are taken into account. The demarcations of short-term and long-term therapy are also important points.

- 4) Striving toward genuineness: For example, making use of discussions from various forms of selfhood, i.e. the levels of a Parent, Adult or Child. Judgemental or labelling statements should also be minimized, especially during initial therapy sessions.
- 5) Setting up for meeting a person: For example, interpretative statements might cause a loss of trust, even if they turn out to be correct. However, the use of so-called desensitization, or gradual acclimation, as well as the so-called thought-stop-exercise and suggestion are also popular procedures.
- 6) Avoiding and preventing games: Patients coming to a therapist often play certain games, such as the yes-but-game. This means giving excuses; for instance, a patient might respond to a suggestion to get more physical exercise with an excuse along the lines of “yes, but there is this and that...”, and achieving a sort of victory by confusing the therapist like this. It is also emphasized that suggestions given to a depressed person such as “try to cheer up” only make their situation worse.
- 7) Striving towards concreteness: Utilizing programmes to control symptoms and certain homework-like tasks. Physical treatment and psychotherapy are used in combination. This is explained in the following way: Bleak thought processes and depressing bodily functions are central to depression. They form a stressful situation via emotions and bodily sensations, in which bleak thought processes affect depressing bodily functions, and these bodily functions produce interpretative bodily sensations that affect the bleak thought processes. This cycle is depicted in the following graphic:



The treatment of depression then focuses on a sort of fight between the two clashing “fists” shown in this diagram (thought processes and bodily functions).

The following points must be included in the **evaluation and measurement of the success of psychotherapy**:

- Simple correlations with an alleviation of symptoms are not enough for studies of effectiveness. External evidence, clinical expertise and patient’s situational data must also be examined. However, there are therapy techniques that correlate strongly with alleviated symptoms, and which can be utilized by many schools of psychotherapy.
- The successfulness of therapy is best predicted by the cooperation relationships between the patient and the therapist, as well as the patient's personal factors, such as their motivation for treatment.
- Accounting for a follow-up period of roughly five years and the use of mental health care services after therapy yield significantly different results from simply comparing the situation at the beginning and end of therapy.
- Studies of effectiveness in medicinal research contain methodological assumptions that do not correspond to the nature of the psychotherapeutic process. After all, psychotherapy revolves around unique interpersonal relationship, and not a single substance like with medicine.
- An important consideration in comparing the effectiveness of the various schools of psychotherapy is that a therapist always selects different information from various schools, thus leading to the following thesis: There are no successful forms of therapy, only successful therapists.

As such, there are numerous answers to the question of how and why psychotherapeutic changes occur. Processing these resembles the analogy of blind people arguing over what an elephant is. Some think they have firm evidence of it being a column, while others think it is a hose, and so on. However, the reality of the elephant is more difficult to define, like attempts to reduce mental malaise, disorders, and negative exceptional behaviour.

Various **reasons and affecting factors** in predictive and preventative work that focus on mental malaise, disorders and negative exceptional behaviour can be categorized thus:

- I **LONELINESSES**: Situations that primarily deal with subjective (positive or negative) isolation, sense of alienation, anomie (sociological), separation angst etc.
- II **MODELS**: Situations that primarily involve the opportunity for social learning.
- III **ACTUAL STRESSFUL SITUATIONS**: Situations that primarily involve all the following factors: 1. Something unpleasant has happened. 2. The sense of unpleasantness is known to continue unless one acts in a certain way. 3. There are difficulties acting in that specific way.
- IV **SENSATIONS OF PUNISHMENT / DISSAPOINTMENT**: Situations in which certain kind of behaviour has resulted in an unpleasant experience.
- V **LOSSES**: Situations involving significant sensations of loss.
- VI **OPPORTUNITIES OF AVOIDANCE OR ESCAPE**: Opportunities to avoid anxiety in a way that in the long term increases anxiety; for example hiding secrets, lashing out, using narcotics or other methods of escape, detrimental defensiveness or coping.
- VII **EXPERIENCING CHANGES WITHOUT IMMEDIATE UNPLEASANTNESS**: Changes in circumstances that do not involve losses or failures, but which are nevertheless new and significant to a person, such as moving to a new place.

These reasons affect the following **cornerstones of well-being**:

- A) INTERPERSONAL RELATIONSHIPS: Friendships, comradeships, acquaintanceships, comparisons of self to others, one's social development level etc.
- B) EXERCISE / BODILY FUNCTIONS / EXERCISE: Motor development level, activities primarily related to the development of muscles, exercise, maintaining bodily fitness, and relaxation, as well as physiological activity.
- C) RATIONAL ACTIVITY: Cognitive development, actions, thinking, studying, planning, organization, living etc. related to daily living.
- D) LIFE PHILOSOPHICAL AND IRRATIONAL ACTIVITY: Emotional, ethical, and aesthetic development, activity primarily related to religion, art, values, beliefs etc., answering God's call etc.

The following results can be drawn from examining the similarities between **predictive mental health care work and the realization of psychotherapy**.

- 1) Loneliness: One of the subcategories of processing loneliness is a respectful and unconditional approach to the patient in regard to e.g. different religious groups.
- 2) Models: Empathizing with another is related to social learning, for example by examining the so-called unwritten rules of interpersonal relationships, such as the difference between sympathy and empathy.
- 3) Stressful situations: Accounting for realities and limits causes both rationalizational and organizational stress, as well as the stress of competing interpretations.
- 4) Sensations of punishment and disappointment: Striving towards genuineness is related to e.g. processing the disappointment of "not being allowed to be myself". One essential phenomenon of disappointment for psychotherapists themselves is noticing that a patient doubts their genuineness.
- 5) Losses: Setting up for encounters is important in psychotherapy in situations such as when a loss of identity is noticed during therapy; "I don't really know who I am" or "I don't know what I really want".
- 6) Avoidances: Avoiding and preventing games is important in psychotherapy, for example when families exhibit a "mode of exile" or agreements such as "we don't talk about this".
- 7) Changes: Striving towards concretion refers to all positive life changes identified during the therapy period.

The following similarities can easily be identified between the cornerstones of mental well-being and the bases of psychotherapy:

- A) Interpersonal relationships: The language used is an important part of processing interpersonal relationships and therapy.
- B) Exercise / moving about: Discovering new activities and accounting for bodily functions is an important part of promoting all sorts of well-being, and an important tool in psychotherapy.
- C) Rational activity: A part of the structure are working methods used in psychotherapy, as well as the strategies, actualizers and targets in predictive mental health care. A significant similarity can also be identified by considering that a person on their therapeutic journey is very difficult to label as mentally ill, but easy to label as a preventer of exacerbating disorders.
- D) Irrational activity: In psychotherapy, the concept of atmosphere is related to e.g. confidential matters, and in predictive mental health care e.g. to the atmosphere of the target area, in which the so-called great questions of life are processed.

BIBLIOGRAPHY

- [1] Arkowitz, H. (1992) Integrative theories of Therapy. In book: Freedheim, D. (ed.) (1992) History of psychotherapy: A century of Chance. Washington DC: American Psychological Association, p. 261-303.
- [2] Coggan, S. L. (2020) Sacred Disobedience: A Jungian Analysis of the Saga of Pan and the Devil Maryland: Lexington Books.
- [3] Crits-Christoph, P. (2001) Limitations of the dodo bird verdict and the role of clinical trials in psychotherapy research: Comment on Wambold et al. (1997) Psychological Bulletin 122(3), p. 216-220.
- [4] D'Alfonso, S., Santesteban-Echarri., Rice, S., Wardley, G., Lederman, R., Miles, C., Gleeson, J. & Alvarez-Jimenez, M. (2017) Artificial Intelligence-Assisted Online Social Therapy for Youth Mental Health. *Frontiers in Psychology* 2 June.
- [5] Durkheim, É. (1897) *Le suicide. Étude de sociologie*, un document produit en version numérique par Jean-Marie Tremblay.
- [6] de Figueiredo, J. (2007) Demoralization and psychotherapy. A tribute to Jerome D. Frank, MD, PhD (1909-2005). *Psychotherapy and Psychosomatics*, 76, p. 129-133.
- [7] Elkin, I., Shea, M., Watkins, J., Imber, S., Sotsky, S., Collins, J., Glass, D., Pilkonis, P., Leber, W., Docherty, J. et al. (1989) National Institute of Mental Health Treatment of Depression Collaborative Research Program. General effectiveness of treatments. *Archives of General Psychiatry*, november; 46(11), p. 971-82; discussion 983. doi: 0.1001/archpsyc.1989.01810110013002.
- [8] Flückiger, C., Del Re, A., Wampold, B. E., Horvath, A.O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*. 55 (4), p. 316–340. doi:10.1037/pst0000172.
- [9] Frank, J. (1961) *Persuasion and healing: A comparative study of psychotherapy*. Baltimore: Johns Hopkins University Press.
- [10] Fredriksen, P. (2012) *Sin: The Early History of an Idea*. Princeton: Princeton University Press.

- [11] Geuras, D. (1992) In defense of divine forgiveness: A response to David Londey. *Sophia*, Springer a. Netherlands vol 1:1. DOI: 10.1007/bf02772354.
- [12] Granville, J.M. (1883) *Nerve-vibration and excitation as agents in the treatment of functional disorder and organic disease*. London: J& A Churhill.
- [13] Guidano, V.F. (1991). *The Self in process: toward a post-rationalist cognitive therapy*. New York, The Guilford Press.
- [14] Guidano, V.F. ja Liotti, G. (1983). *Cognitive processes and emotional disorders*. New York, London, The Guilford Press.
- [15] Heijenoort, J. (1967) Logic as calculus and logic as language. *Synthese* 17, p. 324-330.
- [16] Heiska, J. (2016) *Better Mental Health with 7x4-field*. Saarbrücken: Lambert Academic Publishing.
- [17] Hohaus, R. (1950) *Recent Social Security Amendments – An Appraisal*. Washington: American Economic Security.
- [18] Jacobson, E. (1938) *Progressive Relaxation*. Chicago: University of Shicago Press.
- [19] Knekt, P., Lindfors, O., Renlund, C., Sares -Jaske, L. Laaksonen, M. A. & Virtala, E. (2011) Use of a. auxiliar psychiatric treatment during a 5-year follow-up among patients receiving short- or b. long-term psychotherapy. *Journal of Affective Disorders*, 135(1-3), p. 221-130.
- [20] Laska, K. (2012) *The cost of determining the marginal efficacy of empirically supported treatments*. a. Wisconsin: University of Wisconsin-Madison.
- [21] Leão, D. (2012) “Asebeia”, in Roger S. Bagnall, Kai Brodersen, Craige B. Champion, Andrew i. Erskine, and Sabine R. Huebner (eds.), *The Encyclopedia of Ancient History* (Oxford, Wiley-Blackwell, 2012), p. 815-816.
- [22] Levy, K. & Scala, J. (2012) Transference, transference interpretations and transference-focused a. psychotherapies. *Psychotherapy*, 49, p. 391-403.
- [23] Lilienfeld, S. O, Steven, J. L. & Lohr, J. M. (toim.) (2003) *Science and Pseudoscience in Clinical a. Psychology*. New York: Guilford Press.
- [24] de Man, P. (1982). *The Resistance to Theory*. Minneapolis: University of Minnesota Press. p. 3–20.
- [25] Meakin, J. (1997) *The Concepts of Sin in the New Testament*. Good News, March-April.
- [26] Morris, S. (2003) A metamodel of theories of psychotherapy: A guide to their analysis, comparisons, i. integration and use. *Clinical Psychotherapy and Psychiatry* 10, p. 1-ym. (2004).
- [27] Ojanen, M., Kotakorpi, S., Kumpula, S., Tenkku, M., Vaden, T., Kiviaho, M., Vikeväinen-Tervonen, i. L. & Hiltunen, S. (2004) *Terapiastako ratkaisu – NLP-perustaisen psykoterapian tuloksellisuustutkimus*. Helsinki: Ai ai oy.
- [28] Peterson, C., Becker, C., Treasure, J., Shafran, R., Bryant-Waugh, R. (2016) The three-legged stool a. of evidence-based practice in eating disorder treatment: research, clinical, and patient b. perspectives. *BMC Med*, Apr. 14:69. doi: 10.1186/s12916-016-0615-5.
- [29] Rechart, E. & Ikonen, P. (1994) Häpeä psyykkisen lamaannuksen aiheuttajana. *Lääketieteellinen a. aikakauskirja Duodecim* 110(3), p. 278-.
- [30] Rogers, C. (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of a. Consulting Psychology*, 21(2), p. 95–103.
- [31] Shapiro, F. (1989) Efficacy of the Eye Movement Desensitization procedure in the treatment of tramat. ic memories. *Journal of Traumatic Stress*, 2(2), p. 199–223.
- [32] Stiles WB, Shapiro DA, Elliot R. (1986) "Are all psychotherapies equivalent?" *Am Psychologist* a. 41(2), p. 165-180.
- [33] Turing, A. (1950) Computing Machinery and Intelligence, *Mind* LIX (236) p. 433–460, doi: 10.1093/mind/LIX.236.433
- [34] Walz, J. Addis, M. E., Koerner, K. & Jacobson, N. (1993) Testing the integrity of a psychotherapy i. protocol: Assesment of adherence and competence. *Journal of Consulting and Clinical Psychology* 61(4), p. 620-630. doi: 10.1037/0022-006X.61.4.620.
- [35] Wampold, B. E., & Imel, Z. E. (2015) *The great psychotherapy debate: The evidence for what makes a. psychotherapy work*. New York: Routledge/Taylor & Francis Group.
- [36] Weizenbaum, J. (1966) ELIZA a computer program for the study of natural language communica- a. tion between man and machine. *ACM Commun* 9, p. 36–45. doi: 10.1145/365153.365168.
- [37] Williams, W. F. (toim. 2000) *Encyclopedia of pseudoscience: Neurolinguistic programming*. Chicago: i. Fitzroy Dearborn.