Ah, D., you are an engineer! From an engineering testing institute!

Psychotherapy, after the psychoanalytic crowd was ushered out, and the flamboyant, charismatic, colourful “family therapy” enthusiasts abated when “managed care” funders took over health services, eventually came up with “empirically verified” treatments/therapy (EVT) to substantiate basis for funding psychological and counselling service delivery. It sounded all well and good; I got quite interested and with what knowledge of statistics and research design I had gained in grad school—my Master’s Thesis was as quantitative as I could make it, and when it was all wrapped up, my Stats adviser woke up to tell me “We should have added a treatment condition and made it a Ph.D."!—I probed the research literature seriously.

Unfortunately, human psychological processes do not prove at all as easy to quantify as STEM phenomena. To begin with, researchers cannot agree on what those “processes” really are. Then, just what constitutes “successful” treatment is a matter of debate. And who gets to decide? Therapists? They are prone to biases (in their own favour) and blinkered viewpoints. The client? He or she too has her own motivations and “needs” to satisfy (or pretend are satisfied or insist have not been met). Completing a rating scale does not make it any less subjective. Further, a charismatic therapist can convince clients that their treatment response was impressive and valid. But was it? And for how long? Do clients have to feel the same way a year from now, or even six months later, for the treatment to have been effective? Factor in the placebo effect—the simple product of someone engaging the troubled client with hope promised—and regression to the mean (people tend to rebound from lows without help), and things become even more problematic. Subjectivity of course has its necessary place, as does objectivity, but this thorny problem is anything but simple to untangle. I am inclined to think it impossible.

The gold standard Double Blind approach has proven very difficult to accomplish convincingly here. For instance, given all the above factors complicating things, to address the placebo effect issue, providing clients with comparative treatment “counselling” that looks like such, but really is nothing beyond basic relationship, fools no one. Even in medication trials for psychotropics, many of the people getting the sugar pills tend to soon catch on.

Add in the problems of statistical analysis. Group differences might be identified, but if you have ever examined scatter plots of psychological

research, you realize “significant differences” are often not nearly as neatly defined as “conclusions” would insist. Overlap, outliers and how are they defined and handled? Why is this guy an outlier? Did something quirky about the treatment fit him perfectly? What you do with outliers can make a big difference. Further, what might be “statistically” significant might not be “clinically” so (actually indicating sufficient “real life” benefit). And in other statistical methods, when you see the data from which “line of best fit” has been derived for other kinds of analysis and comparison, you may well be less convinced that “the truth” has been adequately identified.

You may by research design of sufficient scale compensate for individual therapist and client differences, but in the summative measures derived, do you lose the grainy texture that allows genuine competence, and accomplishment, to be identified and recognized adequately?

As well: The nature of the psychopathology being treated matters hugely. Therapy with sexual abuse victims differs—should differ—significantly from that with clients suffering “simple” depression or the exasperations found in couples/marital therapy. One therapeutic approach, Cognitive Behavioural Therapy (CBT), has emerged from the EVT initiative as statistically proven to be effective. I want to spit every time I come across it. CBT, scripted and programmed (whatever protestations otherwise), is more about making the lives of therapists easier than those of clients. But the standardized procedure the client is walked through (by a practiced deliverer)—with some I admit worthwhile psychological exercises completed—produces modest results at best, and I think does not work adequately with the severely complicated “unwell.” CBT’s only merit is that it provides a method with some scrutinized merit in a psychotherapy/counselling field riddled with utterly “uninspired” sellers, however well-meaning, of bilge. They really have no idea of what they are doing beyond the immediate moment. I can count on one hand the psychologists, counsellors, and psychiatrists I would go to confidently for help. (Uncle A’s amputated right hand might suffice.) Any that have proven effective have graduated to just writing books about therapy.

This has not stopped the defenders and promoters of psychotherapy from carrying on with the EVT initiative. A lot is at stake, including professions competing at funding water holes, livelihoods, and careers. The literature and research is worth something, but I do not think it “answers” the “questions” nearly well enough. As long as this is recognized, it is worth exploring, if only to

gain a better understanding of what psychotherapy is all about—or rather, *should* be all about according to different purposes and intentions for it.

Unfortunately, therapeutic matters like child sexual abuse have tended to be subsumed within the "trauma" literature rampant now. Being violated sexually as a child is different than just surviving the emotional depravations, and physical abuse, of residential school. Further it all gets lumped in with PTSD, which is now the "abuse" classification of choice; coming home from Iraq with your neurons devastating rearranged by percussive blasts is different from being fondled by your grandfather. In the PTSD treatment field, last I looked, the best and most innovative progress being made was in scientifically informed nonverbal, body treatment methods for the neurologically crippled. In my opinion the best chances of real, lasting, transformative success in the treatment of child sexual abuse lie in the intuitive personalized intervention of a gifted therapist/healer who is prepared to bravely walk through terrible territory with the client competently and confidently prepared and able to safely go, as necessary, employing hypnosis and perhaps "regressive therapies," off the maps (professional college ethics stick to) on which the client is stuck. Such people I am sure exist—and do not register in EVT terms—but good luck in finding one. The meagre returns of the likes of CBT are the most that we can hope for, and the best must be made of these.

So, this being said, I still believe there are talented, gifted therapists safe to wade confidently into the treacherous terrain of exploring and treating the psychic fallout from child sexual abuse. They are worth their weight in gold; I suspect, though, that they are about as common as the leprechauns who know where that gold lies—when it does—under rainbows, and guard it.

Take care

Trevor