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van Oenen, F.J.

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CHAPTER 2 *A TRIPLE-ROLE MODEL FOR THE PSYCHIATRIST*

A triple-role model for the psychiatrist; a scientific, contextual and personal approach in psychiatry

F.J. van Oenen, S. van Deursen & J. Cornelis

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Samenvatting

Traditionele pijlers van psychiatrische behandeling zoals diagnostiek en specifieke werkzaamheid van behandelmodellen staan in toenemende mate ter discussie. Daarentegen krijgen andere, ‘nonspecifieke’ behandelfactoren zoals de kwaliteit van de samenwerkingsrelatie, het belang van feedback en de persoonlijke inbreng van de behandelaar steeds meer aandacht. Tevens is er vanuit de samenleving een steeds dringender vraag om behandelingen vorm te geven via *shared decision making* met de patiënt en diens naasten. Om tegemoet te komen aan deze veranderende inzichten stellen de auteurs een model voor waarin de psychiater meerdere rollen in het behandelproces vervult. In dit Drierollenmodel kan de meerwaarde van de verschillende referentiekaders en gespreksmodellen beter tot uitdrukking worden gebracht dan in de traditionele psychiatrische ‘*rules talk*’.

Abstract

There is increasing debate about the traditional cornerstones of psychiatric treatment such as medication, diagnostics and the specific effectiveness of therapeutic models. At the same time, there is a stronger focus on other, ‘non-specific’, factors like the quality of the working alliance, the importance of feedback and the person of the therapist. Furthermore, society at large is pushing for a more prominent position for relatives in the treatment process.

In response to these developments, the authors propose a new role concept for the psychiatrist.

The authors analyse the relationship between a range of roles and a range of conceptual frameworks, conversation models and the use of language, and argue that psychiatrists should be able to fulfil different roles in the treatment process. The traditional psychiatric ‘rules talk’ provides limited opportunities to draw on the added values of different roles and conceptual perspectives.

The decision to adopt a specific role – and conversation model – for the psychiatrist should be based on the following question: ‘Which role is most likely to result in optimal cooperation with the patient and relatives?’

An all-encompassing language is needed to reflect on different choices.

Introduction and background

Some of the foundations of traditional psychiatric treatment are under attack (Bracken et al., 2012; McGorry & van Os, 2014). Although medication and psychiatric/neuropsychiatric diagnostics continue to be important elements of the discipline, there have been hardly any significant developments in this area in recent decades (Priebe et al., 2013a). The randomised controlled trial as the gold standard for the assessment of therapeutic models has been criticised (Wampold & Imel, 2015), it has emerged that the different psychotherapeutic treatment models have similar levels of effectiveness (Cuijpers, 2008; Imel et al., 2008) and it has not proven possible to find any specific identifiable factors that account for the effect of a treatment (Wampold, 2015). At the same time, there is a rising tide of publications that emphasise the importance of the therapeutic alliance and 'common factors' such as client hope and therapist confidence in the method (Thompson et al., 2012). There is also increasing interest in 'therapist effects' (Miller et al., 2013). It has emerged, for example, that there is a greater difference between the effectiveness of individual therapists than between the various models (Wampold & Brown, 2005). McKay et al. (2006) even found that the most effective psychiatrists achieve better results with placebos than less successful colleagues using effective medication. It has also been found that revealing therapists' personal thoughts or emotions is associated with better treatment outcomes (Levitt et al., 2015).

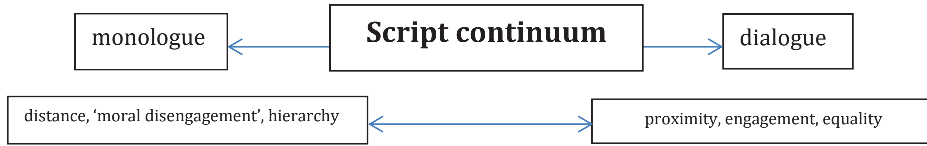
In addition, society at large is urging professionals to devise treatment plans in consultation with patients' relatives. This is supported by increasing evidence that the alliance with clients and relatives is a crucial element in the treatment (Crits-Christoph et al., 2011), that the involvement of relatives can improve treatment results and that shared decision-making has a positive effect on the empowerment of clients (Stovell et al., 2016). The need to involve the social context in treatment has therefore already been included in various APA guidelines. Psychiatrists need to work in ways that do justice to these changing demands from society and scientific insights. The direction that this thinking about the profession should take is a topic of serious debate (Bracken et al., 2012). Various authors (Slade et al., 2009; Ventriglio et al., 2016) argue that 'mental illness and interventions in psychiatry should be considered in the framework of social context' and that there should be a greater focus on the alliance with the patient and relatives, with emphasis being placed on concepts such as 'concern' and 'engagement'. Against this background, a group of psychiatrists have asked for therapies to be designed more in collaboration with the client system on the basis of client-centred models

like shared decision-making (Bracken et al., 2012). They argue that: 'We are not seeking to replace one paradigm with another. A post-technological psychiatry will not abandon the tools of empirical science or reject medical and psychotherapeutic techniques (...)'. 'We need to develop (…) a different understanding of our *role* as doctors' (p. 432).
However, they do not elaborate on what this means for them in practice. In this article, we aim to describe a new approach to the role of psychiatrists.

Awareness of roles, conceptual frameworks and scripts

Human communication is founded on the ability to fulfil social roles (Biddle, 1986). We propose an approach in which perspectives are not defined on the basis of therapies or diagnostic classifications but using the different roles that psychiatrists can fulfil in the therapeutic process: the expert, the process consultant and the participant. As Bracken et al. (2012) have suggested, this involves using different perspectives alongside one another.
Each role is linked to a specific conceptual framework or assumption. Malinen (2006) distinguishes between three types of knowledge underlying the approaches adopted by psychiatrists. The first type of knowledge, linked to the expert role, represents the scientific approach (Newton, 1687). The second type, linked to the process consultant role, represents the systemic approach (Capra & Luisi, 2014). The third type, linked to the participant role, represents the person-based approach. In systems theory, the first two forms of knowledge are also referred to as '1st-order thinking' and '2nd-order thinking' (Hoffman, 1985). We could refer to the third type of knowledge as '3rd-order thinking'. These three types of knowledge have been described, in a more philosophical sense, by Shotter as 'knowing that', 'knowing how' and 'knowing how to go on' respectively (Shotter, 1993; Rober, 2005).

The role of the psychiatrist in the treatment has, in turn, implications for the conversation and for non-verbal communication. In this chapter, we use the concept of 'script' (Bying-Hall, 1995) to describe the selected form of conversation, and the resulting conversational processes and conduct.
Each role involves a specific script in which elements such as distance, engagement and division of responsibility can vary greatly. Numerous scripts may be used for therapies. On a continuum, the most extreme scripts can be typified as 'monologue' and 'dialogue', in which the monologue involves distance and differing levels of responsibility, and the dialogue proximity and equal responsibility. Any conversation will involve a dynamic tension between these two extremes (Shotter, 1993).



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Three basic roles of the psychiatrist

Duncan (2010) writes about the role of the therapist: 'The role you assume can be quite different with different clients, depending on what you and the client negotiate will be most useful (...) some clients want a sounding board, (…) some want to (…) problem solve, many want a collaborator and some want an expert to tell them what to do' (p. 149). Here, we define the three main roles for the psychiatrist and describe the related scripts and conceptual frameworks. The roles described overlap with communication styles ('following', 'directing' and 'guiding') as described in motivational interviewing (Rollnick, Miller & Butler, 2009). However, a role in the triple-role model is much more than just a communication style. The model connects the communication form, attitude and conceptual framework, with each role being inseparably linked to an appropriate theoretical framework and conversation model.

The expert

The role of the psychiatrist defined from a scientific point of view is that of an outsider who has exclusive expertise: an *expert.* The expert has the intention to observe the patient, to identify the disorder and to remedy the disorder in a specific way.
Thinking based on exact sciences assumes linear causality. Something is either true or false. This dichotomous perspective makes it possible to verify or disprove assumptions, a fundamental component of research in the exact sciences. The reduction of complex systems makes classification and diagnostics in clear categories possible, as well as a distinction between 'health' and 'disease'. Expert judgement is needed to diagnose pathology/psychopathology. In this context, a functional 'dehumanisation' of the medical practitioner – in the form of limiting empathy and 'moral disengagement' – is useful and necessary in order to make assessments based on scientific evidence. The underlying principle that research findings need to be universally applicable has generated important

understandings about areas like genetic predisposition, the efficacy of pharmaceutical drugs and specific psychotherapeutic factors.

The associated script most resembles the monologue form, in which statements from the patient are interpreted on the basis of the expert's conceptual framework, resulting in a prescription from a professional who is higher in the knowledge hierarchy. The most explicit monologue script is the ordering of a compulsory admission. Other examples include prescribing a protocol-based therapy and applying psycho-education. The aim of this script is to apply expert knowledge and transfer it to the lay person.

Psychiatrists evaluate their interventions in the context of this framework by observing changes in symptoms in the light of specific interventions.

The process consultant

The psychiatrist is lower in the hierarchy than patients or the social network in terms of contributing substantive knowledge. In systemic theory, this position is described as 'not-knowing': therapists put their own expertise about 'illness' to one side (initially) and they are open to all possible explanations. In this role, psychiatrists are experts in therapeutic conversation (Boeckhorst, 1997) who, while observing, are part of the process. They do not make judgements and they guide the process of collaboration in such a way that a consensus is established about the issues that need to be addressed, opening up the way to find appropriate solutions (van Oenen et al., 2012). This role is described by Duncan (2010) as that of a 'collaborator'; van Oenen et al. (2012) refer to this role as the 'process consultant'.

It draws on the expertise of the therapist, and that of the patient and relatives. The psychiatrist contributes his knowledge of strategic process control, systemic hypothesis generation and structuring conversational skills.

Relational and contextual factors and the power of the 'system' are central assumptions in a process-based approach. From a systemic perspective, relationships are seen as reciprocal (or circular) and several points of view can exist alongside one another. The premise is that diagnoses do not represent objective truths; they are rather constructs that are effective in some contexts and not in others. Several explanations may be valid . In this context, the therapist has the intention to have an effect on interactions and patterns – in the here and now – and to further collaboration between client and relatives. Evaluation takes place in consultation with both the patient, the 'ill person' and the patient's social network. This fits in with demands from society at large to involve the social network and to deliver 'collaborative care'.

A hybrid monologue and dialogue form is the result, in which statements made by those involved in the conversation are interpreted in an interactional conceptual framework geared towards mutual understanding. The associated scripts are ‘learning through experience’ and ‘shared decision-making’. The aim of scripts of this kind is to allow all those concerned to rediscover their own strengths and resources. Examples from mental-health practice are system therapy, inter-subjective psychodynamic therapy and dialectical behaviour therapy. Here, assessments of the progress of treatment are made during the treatment at joint evaluation moments, which may be formalised or not. The assessment focuses less on symptoms and primarily on developing the general well-being or recovery of the ‘ill person’ and the therapeutic alliance.

The participant

In this role, psychiatrists are on an equal footing with their patients, they are open to changes in themselves (Hayes et al., 2004) and they reflect on remarkable, striking moments in the meeting. A therapy session is a ‘meeting of living persons’ in which the therapist reflects on the basis of an ‘experiencing self’ (Rober, 2005). We describe this role as that of a *participant*. The participant shows interest and involvement by sharing and regulating emotions. Spontaneous interactions, which are often largely on the relational level and manifested unintentionally (in part), can affect the outcome of the treatment through an ‘embodiment of love’ and ‘being where the other is’ (Seikkula, 2011; Levitt et al., 2015).
In this ‘personalised’ approach– unique – personal and interpersonal factors such as ‘the psychiatrist’s character’ and the ‘common factors’ are thought to be the most important factors in the therapeutic process (Miller et al., 2013).
The participant looks for spontaneous exchanges based on equality. He does this in a ‘person-to-person dialogue’ without assumptions or prior intentions. In this role, there is no search for explanations because neither one explanation nor the other is considered to be adequate (‘neither/nor’ paradigm).
New meanings are found only in the transient moment. In addition, when the process consultant role is adopted, there may be some reflection in hindsight about the possible effects of this exchange. Here, thinking is dominated by the interpersonal, ‘normal’ element in the therapeutic process and the focus is on establishing a relationship (Rober, 2005).

Although neither assumptions nor intentions underlie the actions of the psychiatrist here, the conceptual framework of humanistic and Buddhist thinking can help psychiatrists to 'stay in the present' and restrain automatic professional behaviour or defensive reactions.

There is a seemingly paradoxical 'structured spontaneity': in the participant role, the therapist has no specific objective for the interview but the introduction of personal elements can unintentionally have a positive effect on the outcome of the treatment (Levitt et al., 2015). The philosophy of humanism, attention exercises from mindfulness and flexibility training from theatrical improvisation art can help the therapist to create the optimal conditions for this interpersonal encounter. The associated scripts use dialogue, which excludes causal explanations and focuses on contingency (or 'coincidence') and subjectivity. From a humanistic perspective, the outcome of this script is the personal development of all those who participate in the conversation. Examples in practice are mindfulness treatment and psychosis therapy based on the 'open dialogue approach' (Seikkula, 2011).
In this approach, the frame of reference dictates that it is not possible to assess the effectiveness of interventions because there is never any predetermined goal. Evaluation takes place in the form of individual feedback about the collaborative process in which the psychiatrist as a person is also a potential subject of discussion.

Different conceptual frameworks, different discourse

Adopting different roles is also a potential source of confusion because the conceptual frameworks on which the roles are based involve distinct terminologies (or 'therapeutic discourses'). For example, Schwartz and Sharpe (2011) distinguish between 'rules talk' and 'wisdom talk': 'Rules talk urges us to consult a code, wisdom talk urges us to learn from others (…)' (p. 44). The discourses used direct us towards distinct types of thinking so that apparently identical interventions can be evaluated in very different ways.
In this way, an intervention such as 'psycho-education' can be used on the basis of different conceptual frameworks for different goals and with different scripts. Similarly, the effect of personal engagement can be seen from the expert's perspective as unprofessional bias, whereas it can be a functional element from the perspective of the process consultant (in other words, a way of 'lubricating' collaboration geared towards the achievement of therapeutic goals), or a liberating and healing interaction from the perspective of the participant.

Medical therapeutic discourse

A problematic consideration is that the existing psychiatric therapeutic discourse is still largely based on a scientific, medical model despite the fact that the therapeutic considerations of the psychiatrist are usually much more wide-ranging. In this discourse, the role of therapist implies the objective diagnostician and the associated assumptions that patients, therapists and disorders can be divided into universal, homogeneous categories and that therapeutic processes can be reduced to specifiable effective components.

A contextual, systemic framework involves a different discourse. Here, concepts such as circularity and 'multidirected partiality' best reflect the aims pursued and the means, and the focus is on the professional process of collaboration with the 'identified patient' and the relatives, exploring relationships and the context, and not on individual diagnosis.

A person-based conceptual framework will require yet another type of discourse in which concepts such as engagement, humanity and wisdom are a better expression of the underlying philosophy. The focus is on experiencing the interpersonal encounter and not on diagnostics or a strategic alliance.

There is hardly any place at all in biomedical discourse for contextual and personal therapeutic considerations of this kind. This often creates confusion since it is difficult for the psychiatrist to decide in which light therapeutic considerations should be seen.

The benefit of the triple-role model is that psychiatrists can consider carefully and state clearly – for themselves and others – which framework underlies their approach at a given moment: an 'object-oriented' scientific approach, a 'context-oriented' collaborative approach or a 'subject-oriented' personal approach. The evaluation of the effect of an intervention can then thereby be made using the appropriate criteria*: symptom reduction* when the focus is on biomedical knowledge, *greater resilience among all those involved* when the focus is on input from the social network, and *more equality and unique experiences* when the focus is on personal input.

To do full justice to the different perspectives, a discourse is required that can facilitate multiple conceptual frameworks.

The triple-role model: the optimal use of different roles

The risk of not-acknowledging the interaction between role, script and conceptual framework is that the strengths of the different roles will be under-exploited. For instance, the role of expert can instil hope and motivation in the patient. However, this process can be

undermined if the psychiatrist introduces a script that is not appropriate for the role, by placing a strong emphasis on personal considerations or by introducing uncertainty about the outcome of a process. This is supported by research findings from Priebe et al. (2013b), who state that personal statements by the psychiatrist (or poor timing in this respect) can reduce patient confidence. Conversely, the role of process consultant can encourage a patient system to tap into its own unique resources, but this process can fail if the psychiatrist, for example, at the same time places a strong emphasis in a hierarchical way on the importance of a psychiatric diagnosis and medication. An awareness of the adopted role allows the psychiatrist to make the best use of the selected role model. The different roles, the associated scripts and the conceptual frameworks in the triple-role model are shown in the figure.

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Triple-role model

Role	*Expert*	*Process consultant*	*Participant*
Script	*Monologue*	*Monologue and dialogue*	*Dialogue*
Focus	*Disorder (‘disease’)*	*Patient and relatives (ill person and persons concerned)*	*Interpersonal experience (‘normality’ and personal engagement)*
Objective	*Increasing knowledge*	*Broadening perspective*	*None*
Instrument	*Follow protocol, historically determined*	*Change context, future-oriented*	*Use yourself, in here and now*
Discourse/ concepts	*Diagnose, objectify, prescribe, treat, cure*	*Understand, patterns, consensus, change, recovery, care*	*Meeting, inspiration, creativity, acceptance, wisdom, compassion*
Feedback	*Formalised pre- and post-measurements*	*Immediate outcome measurement, formal or informal*	*Informal reflection, personal evaluation*
‘Locus’ of change	*Specific factor: expertise of psychiatrist*	*Non-specific factor: professional/ therapeutic alliance*	*Non-specific factor: character of psychiatrist, ‘therapist factors’*
Legitimacy	*Evidence-based practice (EBP)*	*EBP and PBE*	*Practice-based evidence (PBE)*
Typical philosophy/ discipline	*Exact science, object-oriented*	*System theory, context- and relationship-oriented*	*Humanism/ Mindfulness, subject-oriented*
Causality model	*Linear causality*	*Circular interactions in relationships*	*Contingency and subjective interpretation*
Paradigm	*Either-Or*	*Both-And*	*Neither-Nor*

Engagement and repairing ruptures

A good relationship with the patient is a strong predictor of a good treatment outcome (Norcross, 2011). This means that it is important for psychiatrists to select their role and the resulting script in such a way that there is the best possible match with the needs, expectations and abilities of the patient system. However, it also implies that it is just as important for psychiatrists, in order to connect with all those involved at any time, to be able to switch between different roles during a therapy.

For instance, when a dangerous situation is seen in the case of an unknown patient, the expert role and the prescription script will generally be selected; the same applies when a patient, given his cultural background, does not recognise the dialogue script. It can also be beneficial when working, for example, with a patient with an autistic disorder to opt for the expert role because a diagnosis from an expert can probably give those involved most grip on the situation. However, when the client and relatives disagree with this judgement, the decision to adopt this role will not result in cooperation and information will not be heard. A more fruitful approach will then be to adopt the process consultant role to explore how patients and relatives explain the situation and which approach they may favour. At all times, the participant role should be adopted regularly in order to establish an alliance and a secure process of collaboration. Sometimes, an 'equal exchange' will ultimately prove to be the preferred script, for example in the case of mindfulness exercises in depression therapy; at other times, this will be a temporary position, as in Acceptance and Commitment therapy, where equal exchanges alternate with behaviour exercises. In the triple-role model, therefore, psychiatrists do not identify exclusively with one of the roles but choose, after careful consideration, the role that seems appropriate to the relevant patient system.

That also means that they will make mistakes, that they should be prepared to acknowledge them and to look for alternatives. Switching between roles can serve to repair ruptures; it is therefore not a sign of failure but precisely an expression of quality and 'opportunities for change' (Schwartz & Sharpe, 2011; Safran & Kraus, 2014). The triple-role model provides ways of assessing the therapist's own role: was the role congruent with the script and did evaluation take place on the basis of the appropriate conceptual framework? Particularly in complicated cases, carefully distinguishing between different frameworks can ensure that therapists do not confuse considerations based on different-order thinking and that they do not assess the effect of interventions using inappropriate instruments. This will prevent situations in which they unnecessarily disqualify other people's expertise or have a

less than appropriate appreciation of their own expertise. In this way, the importance of investing in the alliance with the relatives is not played down ‘because there is no diagnostic classification underlying the therapeutic approach’ and – conversely – the importance of individual limitations is not missed ‘because the underlying principle must be equality’. Equally, formal measurements cannot be used to disqualify the importance of personal involvement and – conversely – informal personal reflection cannot be seen as superior to formal feedback systems.

The assessment of one’s actions on the basis of the triple-role model makes it possible to differentiate between the role and the script, and between the professional and the person. This allows for the optimal tailoring of the approach to the patient and it does more justice to both the expertise of the psychiatrist and the psychiatrist as a person.

Consequences for the profile of psychiatrists

The triple-role model includes both a theoretical foundation and a method. It provides a theoretical description of how psychiatrists should do their work ideally *and* provides a way of finetuning the therapeutic approach.

If this model is adopted as a guiding principle, there are implications for the profile of psychiatrists, since psychiatrists can no longer limit themselves to the role of medical expert and are also accountable for their roles as process consultants and participants. Although other disciplines can be seen in these two last roles, the combination of exclusive expertise and mastery of different roles makes psychiatrists ideally suited to assume responsibility in complex situations where skills in all roles are required.

In a time in which the emphasis – due to the effect of the protocols prescribed by insurers – is exclusively on the role of the expert, the model would have to be tested in a randomised controlled trial to guarantee funding.

However, the decision to adopt this theoretical model can also be based on other arguments: better communication between therapists, more therapist and patient engagement, and increased inspiration, solace and a ‘sense of mastery’ in the patient. So the question is: which measure is appropriate to determine whether the model brings added value?

Conclusion

The triple-role model is a basic model. That does not mean, however, that it is also simple to implement. Putting the model into practice requires a rethinking of both the therapeutic discourse, the conceptual framework and the role of the psychiatrist. The therapeutic discourse of psychiatry is still largely based on the biomedical conceptual framework and it does not provide enough latitude for contextual and personal therapeutic considerations. Non-specific psychotherapy factors and concepts from other conceptual frameworks such as system theory and humanism should have a natural place in the therapeutic discourse of psychiatry if justice is to be done to recent advances in the field.

The realisation that psychiatrist as a person, patient preferences and the quality of the alliance determine the success of a therapy makes it necessary to re-define the role of the psychiatrist in the therapeutic process. It is not enough to fulfil a single role and psychiatrists will have to switch continuously between roles and the associated conceptual frameworks and scripts. This switching is a common feature of day-to-day practice but it is generally done unconsciously, and without reflection, as a result of which it is often unclear how and in what terms results should be evaluated. The triple-role model allows psychiatrists to choose roles deliberately and to reflect explicitly about them and, where necessary, to switch roles and scripts if the fit with the patient system appears to be inadequate.

This allows psychiatrists to contribute scientific knowledge, to reflect about the alliance in a professional and ongoing way and to express themselves in unique, personal ways during the therapeutic process.

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