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The International Journal of Psychotherapy is a leading professional and academic publication, which aims to inform, to stimulate debate, and to assist the profession of psychotherapy to develop throughout Europe and also internationally.

The Journal raises important issues in the field of European and international psychotherapy practice, professional development, and theory and research for psychotherapy practitioners, related professionals, academics & students. The Journal is published by the European Association for Psychotherapy (EAP), three times per annum. It has been published for 24 years.

The focus of the Journal includes:

- Contributions from, and debates between, the different European methods and modalities in psychotherapy, and their respective traditions of theory, practice and research;
- Contemporary issues and new developments for individual, group and psychotherapy in specialist fields and settings;
- Matters related to the work of European professional psychotherapists in public, private and voluntary settings;
- Broad-ranging theoretical perspectives providing informed discussion and debate on a wide range of subjects in this fast expanding field;
- Professional, administrative, training and educational issues that arise from developments in the provision of psychotherapy and related services in European health care settings;
- Contributing to the wider debate about the future of psychotherapy and reflecting the internal dialogue within European psychotherapy and its wider relations with the rest of the world;
- Current research and practice developments – ensuring that new information is brought to the attention of professionals in an informed and clear way;
- Interactions between the psychological and the physical, the philosophical and the political, the theoretical and the practical, the traditional and the developing status of the profession;
- Connections, communications, relationships and association between the related professions of psychotherapy, psychology, psychiatry, counselling and health care;
- Exploration and affirmation of the similarities, uniqueness and differences of psychotherapy in the different European regions and in different areas of the profession;
- Reviews of new publications: highlighting and reviewing books & films of particular importance in this field;
- Comment and discussion on all aspects and important issues related to the clinical practice and provision of services in this profession;
- A dedication to publishing in European 'mother-tongue' languages, as well as in English.

This journal is therefore essential reading for informed psychological and psychotherapeutic academics, trainers, students and practitioners across these disciplines and geographic boundaries, who wish to develop a greater understanding of developments in psychotherapy in Europe and world-wide.

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The IJP Website: www.ijp.org.uk

The IJP website is very comprehensive, with many different pages. It is fairly easy to negotiate using the tabs across the top of the website pages.

You are also able to subscribe to the Journal through the website – and we have several different 'categories' of subscriptions. However, the Journal is now more of an "open-access" journal, so subscriptions are less relevant.

You can also purchase single articles and whole issues as directly downloaded PDF files by using the Catalogue on the IJP website. Payment is by PayPal. We still have some printed copies of most of the Back Issues available for sale.

Furthermore, we believe that 'Book Reviews' form an essential component to the 'web of science'. We currently have about 60 books available to be reviewed: please consult the relevant pages of the IJP website and ask for the books that you would enjoy reviewing: and – as a reviewer – you would get to keep the book. All previously published Book Reviews are available as free PDF files.

There is also a whole cornucopia of material that is currently freely available on-line (see the top left-hand corner of the website). Firstly: there are several "Open Access" books on Psychotherapy available, free-of--charge; next there are an increasing number of free "Open Access" articles; then there are often a couple of articles available from the forthcoming issue, in advance of publication.

There is also an on-going, online 'Special Issue' on "Psychotherapy vs. Spirituality". This 'Special Issue' is being built up from a number of already published articles and these are available freely on-line, soon after publication.

Finally, there are a number of previously published Briefing Papers. There is one on: "What can Psychotherapy do for Refugees and Migrants in Europe?"; and one on an important new direction: "Mapping the ECP into ECTS to gain EQF-7: A Briefing Paper for a new 'forward strategy for the EAP." Because of a particular interest that we have in what is called by "Intellectual Property", we have included a recent briefing paper: "Can Psychotherapeutic Methods, Procedures and Techniques" be patented, and/or copyrighted, and/or trademarked? – A Position Paper." Lastly, as part of the initiative to promote psychotherapy as an independent profession in Europe, we have: "EAP Statement on the Legal Position of Psychotherapy in Europe", which we published in a recent issue.

International Journal of Psychotherapy

Editorial

Marzena Rusanowska

Editor, International Journal of Psychotherapy

I must admit I am a genuine fan of the articles in this issue. Each of them expanded my knowledge or reminded me of things close to my heart. I am thinking about the reflections on Karen Horney, the unfair dominance of positivism in today's therapy world, and the fact that a therapist's own mental health is a core part of the therapy itself. This issue contains only three articles, but they are deep, thorough, and very interesting. I highly recommend them.

James Overholser opens the issue with a simulated interview with Karen Horney, who had a huge and enriching influence on psychotherapy. The format is unusual and this is deliberate. It brings Horney's ideas into a living dialogue instead of a dry historical summary. Her core concepts, like the „tyranny of the should," basic anxiety, and the three interpersonal orientations, still feel clinically fresh. They prove that the history of our field is not just behind us. Thank you, James, for this refreshment!

Next, Susanne Vosmer offers a strong critique of how positivism became so dominant in psychotherapy research, especially in psychoanalysis. Her argument is not just theoretical, it is psychological. She suggests that positivism can serve as an unconscious defense mechanism. It protects us from death anxiety and existential uncertainty, acting as an idealized object that stops critical thinking instead of helping it. The implications for how we design and evaluate psychotherapy research are serious and question the current rules of the field.

The issue closes with an article by Ewa Dobiała, who developed the Vertical Model of Therapist Stabilization. This model was a direct response to prolonged collective trauma, including situations where clinicians work under the conditions of war. Her framework moves from somatic and sensory regulation to affective differentiation, relational attunement, cultural grounding, and existential orientation. What makes this model special is the clear message that a therapist's own stability is not a side issue. It is a clinical and ethical

necessity. The stability of the clinician cannot be separated from the quality of the therapy. It is the very foundation of it.

When you read these three articles together, you see a clear connection. What we inherit from our history, how we think about knowledge, and how we care for ourselves as professionals are not separate questions. In the end, they are the same question, just asked at different levels.

A simulated interview with Karen Horney: Important lessons from a neglected pioneer in psychotherapy

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Abstract: Dr. Karen Horney was a pioneer in the field of psychotherapy. She initially aligned with Freudian doctrine, but as her views sharpened, she pushed for her own perspective, endorsing a feminist view that provides important insights into psychology and mental health. Over the course of her career, Dr. Horney promoted several hallmark ideas including her focus on the "tyranny of the should", confronting feelings of basic anxiety, and a thoughtful understanding of three interpersonal styles characterized by persistent tendencies for moving toward, moving against others, and moving away from other people. The present report summarizes some of her seminal ideas using the format of a simulated interview.

Key words: personality, psychotherapy, neurosis, feminist psychology

Karen Danielson was born in Germany in 1885 and completed her medical training in 1915. She emigrated to the United States in 1932, helped to establish the Association for the Advanced or Psychoanalysis in 1941, and served as the founding editor for the *American Journal of Psychoanalysis*. Karen Horney died of cancer in 1952 at the age of 67 (Eckardt, 2005). In several important ways, Karen Horney can be seen as a neglected hero in the history of psychotherapy. She earned her medical degree at a time when it was uncommon for women to seek advanced degrees. She trained as a psychiatrist with a specialization in psychoanalysis, working with some of the leaders of the field.

Over the course of her career, she provided psychotherapy to a range of clients, and published her view of therapy in books and journal articles. Based on her published works, Karen Horney appeared to be a competent and skilled psychoanalyst. She displayed an awareness of cultural factors and the power of interpersonal bonds during early childhood. In some of her writings,

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she explained her views of the qualities needed to become a skilled therapist, and the creativity involved in effective therapy sessions.

Karen Horney was a true pioneer in the field of psychotherapy, and she was not afraid to challenge the established dogma in the field. As her career developed and her clinical acumen sharpened, she revised and refined her approach to psychotherapy. As she developed her own view of psychotherapy, her views diverged from Freudian doctrine. Some of her ideas foreshadowed several contemporary approaches to psychotherapy. Her notion of the 'tyranny of the should' aligns with cognitive restructuring. Her emphasis on emotional awareness and emotional regulation aligns with emotion-focused therapy. Karen Horney is perhaps the first psychotherapist to confront social comparisons as a destructive tendency when clients evaluate their success by comparing themselves with the abilities or accomplishments of others.

Unfortunately, interest in her contributions to the field of psychotherapy seems to have declined and her views appear to be somewhat neglected by recent scholars (Paris, 1996). It is important for contemporary psychotherapists to remember and respect the ideas proposed by Dr. Horney. The present paper summarizes ideas expressed through a simulated interview with Karen Danielson Horney (KDH) led by James C. Overholser (JCO).

JCO: Thank you for meeting with me. I'd love to hear your approach to psychotherapy.

KDH: "I hardly know where to begin" (Horney, 1980, p. 36). "I cannot possibly present to you today with the entire theoretical basis of psychoanalysis and must, therefore, assume that you are familiar with the theories" (Horney, 1968, p. 3).

JCO: Of course. Perhaps we can start with your view of neurosis.

KDH: "Neurosis basically is a process in which human relationships are disturbed" (Horney, 1991, pp. 220–221).

JCO: So interpersonal relations are key to mental health and mental illness?

KDH: "This is true" (Horney, 1987b, p. 43). "A neurotic development in the individual arises ultimately from feelings of alienation, hostility, fear, and diminished self-confidence" (Horney, 1939a, p. 172). "Human relationships are so crucial that they are bound to mould the qualities we develop, the goals we set for ourselves, the values we believe in" (Horney, 1945a, pp. 46–47). "Every symptom is a more or less direct outgrowth of a conflict" (Horney, 1945a, p. 34).

JCO: Because of your training as a psychiatrist, I thought you would believe that neurosis has a genetic basis.

KDH: "No, nothing of that sort" (Horney, 1980, p. 46). "Many of the factors that we had believed to be constitutional are no more than consequences of blockages of growth, blockages which can be resolved" (Horney, 1968, p. 12). "In my opinion, one has to look not for biological reasons but for cultural ones" (Horney, 1939a, p. 113). "When we realize the great import of cultural conditions on neuroses, the biological and physiological conditions … recede into the background" (Horney, 1937, p. viii).

JCO: So culture shapes our view of what is normal?

KDH: "It is difficult to say where the normal stops and the pathological begins" (Horney, 1945b, p. 137). "I call normal that which

is usual in a given culture" (Horney, 1967, p. 245). "A neurosis involves deviation from the normal" (Horney, 1937, p. 21). "The conception of what is normal varies not only with the culture but also within the same culture" (Horney, 1937, p. 15).

JCO: I thought cultural factors would affect everyone equally within the same culture.

KDH: "Actually, just the opposite is true" (Horney, 1952b, p. 298). "Owing to the purely masculine character of our civilization, it has been much harder for women to achieve any sublimation that would really satisfy their nature, for all the ordinary professions have been filled by men" (Horney, 1967, pp. 69–70). "Now why am I bringing this up here?" (Horney, 1987d, p. 72).

JCO: I guess you feel these issues continue to affect modern society.

KDH: "Am I justified in these complaints?" (Horney, 1980, p. 214).

JCO: Well, yes. I hope the conditions have improved, but yes, they still persist.

KDH: "Psychoanalysis is the creation of a male genius, and almost all those who developed his ideas have been men" (Horney, 1926, p. 324). "A girl is exposed from birth onward to the suggestion – inevitable, whether conveyed brutally or delicately – of her inferiority" (Horney, 1967, p. 69). "The presence of these feelings of inferiority is one of the most common psychic disorders of our time and culture" (Horney, 1936b, p. 224). "At the present time, this conflict confronts every woman who ventures upon a career of her own and who is at the same time unwilling to pay for her daring with the renunciation of her femininity" (Horney, 1934a, p. 606).

JCO: I am glad you raised these issues. I agree that cultural factors have a profound influence.

KDH: "We live in a competitive, individualistic culture" (Horney, 1936b, p. 227). "Narcissistic trends are frequent in our culture. More often than not, people are incapable of true friendship and love; they are egocentric" (Horney, 1939a, p. 98). "Neurotic people are too self-centered and consequently evaluate a partner in terms of their own needs" (Horney, 1950d).

JCO: Let me change topics – Is it important to understand the original cause of a client's struggles?

KDH: "This is true" (Horney, 1987b, p. 43). "When a person wants to understand himself, it is important, beyond any doubt, that he understand the forces that were instrumental in his development" (Horney, 1942, p. 295). "Early relationships in their totality mould the character to an extent which can scarcely be overestimated. Later attitudes to others, then, are not repetitions of infantile ones but emanate from the character structure, the basis of which is laid in childhood" (Horney, 1939a, p. 87).

JCO: It sounds like a supportive childhood is key.

KDH: "The human individual needs favorable environmental conditions if he is to grow up to be himself, to actualize his potentialities, and to have healthy relationships with other people" (Horney, 1956b, p. 24). "If the spirit at home is one of warmth, of mutual respect and consideration, the child can grow unimpeded" (Horney, 1942, p. 43). "Children brought up in a favourable environment grow in a wholesome way to become responsible, mature adults" (Horney,

1951a, p. 54). "A healthy child, growing up in an atmosphere of warmth and reliability, feels sure that it is wanted, does not require constant proof of that fact" (Horney, 1937, pp 123–124).

JCO: What kind of home life is disruptive to the children?

KDH: "In the life history may be found … an atmosphere in childhood lacking in warmth and reliability, but rife with frightening elements – battles between parents, injustice, cruelty, over-solicitousness" (Horney, 1936b, p. 226).

JCO: How will a troubled home life affect the child?

KDH: "In children growing up under adverse conditions, helplessness is usually artificially reinforced by intimidation, by babying or by bringing and keeping the child in a stage of emotional dependence" (Horney, 1937, pp. 85–86). "Through a variety of adverse influences, a child may not be permitted to grow according to his individual needs and possibilities … As a result, the child does not develop a feeling of belonging" (Horney, 1950a, p. 18). "Instead of developing a basic confidence in self and others, the child developed basic anxiety" (Horney, 1950a, p. 366).

JCO: It sounds like anxiety is common in childhood.

KDH: "Basic anxiety … can briefly be described as a feeling of helplessness in a hostile and overpowering world" (Horney, 1967, pp. 257–258). "There are in our culture four principal ways in which a person tries to protect himself against the basic anxiety: affection, submissiveness, power, withdrawal" (Horney, 1937, p. 96). "In a child who feels himself on precarious ground because of his basic anxiety, these moves become extreme and rigid" (Horney, 1950a, p. 19).

JCO: The effects of a troubled childhood persist well into adulthood?

KDH: "If the unfavourable conditions persist, a developmental process sets in – which we call neurotic – which is complicated and essentially unconscious" (Horney, 1952a, p. 68). "As a consequence of such an environment, the child does not develop a proper self-respect. He becomes insecure, apprehensive, isolated, and resentful" (Horney, 1942, p. 44). "A child may feel that he is not wanted or appreciated for his own sake, but that he is acceptable only if he lives up to the expectations of others, especially those of his parents" (Horney, 1939b, p. 130). "He is motivated by plain fear that these powerful giants would desert him, withdraw their reassuring benevolence or turn against him" (Horney, 1937, p. 87). "As long as fear of criticism was operating, spontaneity was positively dangerous" (Horney, 1987c, p. 56).

JCO: It sounds like a happy childhood is vital for a healthy adulthood.

KDH: "This is true" (Horney, 1987b, p. 43). "Like any other living organism, the human individuum needs favourable conditions for his growth … he needs an atmosphere of warmth to give him both a feeling of inner security and the inner freedom enabling him to have his own feelings and thoughts and to express himself. He needs the good will of others, not only to help him in his many needs but to guide and encourage him to become a mature and fulfilled individual" (Horney, 1950a, p. 18).

JCO: In therapy, how do you help clients to overcome a troubled childhood?

KDH: "I want to liberate the inherent urge to grow" (Horney, 1956a, p. 86). "Given favorable conditions, a human being has the natural urge to develop his human potentialities and to realize himself" (Horney, 1950f, p. 278). "Man by his very nature and of his own accord strives toward self-realization" (Horney, 1950c, p. 4). "When we plant strawberry seeds, we do not expect apples to grow … To get strawberries, we must plant the seeds properly, in the right kind of soil, supplying the moisture, sun, and shade required by this particular type of plant" (Horney, 1945b, p. 136). "Like strawberries, love must be cultivated if it is to grow and bear fruit" (Horney, 1945b, p. 139).

JCO: How should parents teach their children?

KDH: "You need not, and in fact cannot, teach an acorn to grow into an oak tree, but when given a chance, its intrinsic potentialities will develop. Similarly, the individual human, given a chance, tends to develop his particular human potentialities. … He will grow, substantially un-diverted, toward self-realization" (Horney, 1950h, p. 13). "Just as a tree needs certain conditions for its growth, so does a child … If a tree, because of storms, too little sun or too poor soil, becomes warped and crooked, you would not call this its essential nature" (Horney, 1952a, p. 68).

JCO: Do you feel some people are naturally good or evil?

KDH: "Man has potentialities for good and evil. He develops into a good human being if he grows up under favorable conditions of warmth and respect for his individuality" (Horney, 1946b, p. 66). "Man is good by nature but that he has, as do all living beings, an innate urge and capacity to realize his given potentialities" (Horney, 1952b, p. 298). "Man has the capacity as well as the desire to develop his potentialities and become a decent human being" (Horney, 1945a, p. 19).

JCO: How can psychotherapy promote a cure?

KDH: "We cannot 'cure' the wrong course which the development of a person has taken. We can only assist him in gradually outgrowing his difficulties so that his development may assume a more constructive course" (Horney, 1950a, p. 333). "The conflicts can be resolved only by changing those conditions within the personality that brought them into being" (Horney, 1945a, p. 217).

JCO: Personality traits seem difficult to change.

KDH: "All of us retain the capacity to change, even to change in fundamental ways, as long as we live" (Horney, 1945a, p. 242). "The therapeutic aim … is not to recapture childhood memories, but to change something in the present attitudes. The knowledge of childhood experiences, therefore, is valuable only insofar as it serves to throw light on the present difficulties" (Horney, 1935b, p. 55).

JCO: I have seen some clients trying to relive a lifestyle that was appropriate for them at a much younger age.

KDH: "The past, in some way or other, is always contained in the present" (Horney, 1939a, p. 153). "The attitudes we see in the adult patient are not direct repetitions or revivals of infantile attitudes" (Horney, 1936a, pp. 43). "Most of these wishes are infantile and they no longer strike us as desirable once they have become conscious" (Horney, 1968, p. 9). "The energies driving toward self-realization are shifted to the aim

of actualizing the idealized self" (Horney, 1950a, p. 24). "The analyst has in mind the growth of the real self" (Horney, 1950a, p. 336).

JCO: How do I confront these immature tendencies without offending the client?

KDH: "We must first of all combat feelings of personal inadequacy and inferiority … Try both by precept and by example to give … the courage to be himself" (Horney, 1939b, p. 132).

JCO: Let me ask about your views of personality.

KDH: "Neurosis … is a basic conflict between the attitudes of 'moving toward', 'moving against', and 'moving away from' people" (Horney, 1945a, p. 18). "A disturbed, unhealthy environment makes the child basically anxious … he cannot grow in accordance with his nature; instead, he moves compulsively toward, against, and away from people" (Horney, 1956b, p. 24).

JCO: Don't we all want to move towards, against, or away from others at different times?

KDH: "Yes, of course you are right" (Horney, 1980, p. 197). "We all have potentialities both for compliance and aggression" (Horney, 1945a, p. 72). "In time, he tries to solve it by making one of these moves consistently predominant – tries to make his prevailing attitude one of compliance, or aggressiveness, or aloofness" (Horney, 1950a, p. 19). "For the sake of simplicity, I shall classify such types as the compliant, the aggressive, and the detached personality" (Horney, 1945a, p. 48).

JCO: Tell me about people who move against others; the aggressive type.

KDH: "A compulsive craving for power and prestige and neurotic ambition … constitute roughly the factors involved in what I shall call 'moving against people'" (Horney, 1945a, p. 14). "Living in a competitive society and feeling at the bottom – as he does – isolated and hostile, he can only develop an urgent need to lift himself above others" (Horney, 1950a, p. 21). "The aggressive type takes it for granted that everyone is hostile" (Horney, 1945a, p. 63).

JCO: The aggressive person sounds egocentric.

KDH: "The neurotic feels entitled to special attention, consideration, deference on the part of others" (Horney, 1950a, p. 41). "Since the world does not recognize his secret claims, he often feels hurt" (Horney, 1939a, p. 96). "A neurotic person feels frustrated all the time" (Horney, 1939a, p. 66).

JCO: How does a person like this cope with this frustration?

KDH: "To answer this question we must consider the role played by competitiveness, rivalry, and ambition" (Horney, 1936a, p. 32). "The problem of competition, or rivalry, appears to be a never-failing center of neurotic conflicts" (Horney, 1936b, p. 221). "The relentless chase after more prestige, more money, more women, more victories and conquests, keeps going, with hardly any satisfaction or respite" (Horney, 1950b, p. 32). "The content of neurotic ambitions is not only to accomplish something worthwhile, or to be successful, but to be absolutely best of all" (Horney, 1936b, p. 222).

JCO: It seems normal to want more money, power and prestige.

KDH: "I should probably explain why I discuss power, prestige and possession

as aspects of a single problem" (Horney, 1937, p. 162). "The neurotic need for power, however, is born out of anxiety, hatred, and feelings of inferiority … the normal striving for power is born of strength, the neurotic of weakness" (Horney, 1937, p. 163). "The striving for power serves in the first place as a protection against helplessness … In the second place … as a protection against the danger of feeling or being regarded as insignificant" (Horney, 1937, p. 166). "The neurotic's ambition is not only to accomplish more than others, or to have greater success than they, but to be unique and exceptional" (Horney, 1937, p. 189). "It is the compulsive drive for power, success, and possessions under the motto. 'If I am stronger, the more successful one, then you cannot hurt me'" (Horney, 1967, p. 258). "If I have power, no one can hurt me" (Horney, 1937, p. 98).

JCO: Doesn't the striving push the person to accomplish goals?

KDH: "A striving for admiration may be a powerful motor toward achievement" (Horney, 1939a, p. 94).

JCO: What happens if they are successful in their career?

KDH: "When they do attain more money, more distinction, more power, they also come to feel the whole impact of the futility of their chase. They do not secure any more peace of mind, inner security, or joy of living" (Horney, 1950a, p. 26). "The relentless chase after more prestige, more money, more women, more victories and conquests, keeps going, with hardly any satisfaction or respite" (Horney, 1950b, p. 32). "The ambition-ridden person can display an astounding energy in order to attain eminence, power, and glamor, yet on the other hand have no time, interest, or energy for his personal life and his development as a human being" (Horney, 1950a, p. 166).

JCO: And the second type is the detached person?

KDH: "Yes" (Horney, 1956a, p. 86). "As long as the detached person can keep at a distance, he feels comparatively safe" (Horney, 1945a, p. 91). "To become emotionally detached from people so that nothing will hurt or disappoint one" (Horney, 1937, p. 99). "When he moves away from people, he wants neither to belong nor to fight, but keeps apart" (Horney, 1945a, p. 43).

JCO: So the quiet loner type is just trying to stay safe.

KDH: "This is true" (Horney, 1987b, p. 43). "We conceive of neurosis as a protective edifice built around the basic conflict" (Horney, 1945a, p. 220). "Any severe neurosis is like a tight armour that prevents the person from having a full and active life with others" (Horney, 1942, p. 290). "A person feels a strong need to distance himself from others but he may also desire affection" (Horney, 1991, p. 221). "A person who can be genuinely fond of others will have no doubts that others can be fond of him" (Horney, 1937, p. 113).

JCO: I understand. I have one client that I liken to an armadillo. Conversation is often slow and difficult.

KDH: "The patient will talk more about things as he senses you are listening and really interested in these problems" (Horney, 1987b, p. 50). "The analyst's belief in and clear recognition of the patient's potentialities helps the patient to regain his faith in himself" (Horney, 1946a, p. 207).

JCO: I have worked with the dependent personality. Is that similar to your third type, the compliant type?

KDH: "Yes, you are right" (Horney, 1980, p. 50). "The dependent people I have been describing have no sense of their own value, no measure of themselves. They get a feeling of worthiness only through others" (Horney, 1945b, p. 138). "A neurotic need for affection, compulsive modesty, and the need for a 'partner' are the nuclei of what I have now drawn together as a 'moving toward people'" (Horney, 1945a, p. 14). "This type needs to be liked, wanted, desired, loved" (Horney, 1945a, p. 51). "The compliant type manifests all the traits that go with 'moving toward' people" (Horney, 1945a, p. 49).

JCO: 'Moving toward others' sounds like a good thing.

KDH: "We all want to be liked and to feel appreciated, but in neurotic persons the dependence on affection or approval is disproportionate to the real significance which other persons have for their lives" (Horney, 1937, pp. 35–36). They lean over backwards to be agreeable, and frequently are apologetic, as well as too yielding, or too appeasing" (Horney, 1950d). "The pervasive feeling that he is weak and helpless" (Horney, 1945a, p. 53). "When moving toward people he accepts his own helplessness" (Horney, 1945a, p. 42). "If only he can find a person who loves him, everything will be all right" (Horney, 1945a, p. 59). "Since getting affection is of vital importance it follows that the neurotic will pay any price for it" (Horney, 1937, p. 119). "The neurotic need for love, which carries the motto, 'If you love me, you will not hurt me'" (Horney, 1967, p. 258).

JCO: But isn't it normal to want to be liked?

KDH: "We all want to and enjoy being loved … the need for love – is not a neurotic phenomenon" (Horney, 1967, p. 245). "While it is important to the healthy person to be loved, honored, and esteemed by those whom he esteems or on whom he is dependent, the neurotic need for love is compulsive and indiscriminate" (Horney, 1967, p. 246). "The need for affection and approval … entails a frustration of the real self" (Horney, 1950a, p. 141).

JCO: I'd like to hear your thoughts about the goals and process of psychotherapy.

KDH: "The goal of psychoanalytical therapy … is not only to remove the symptoms but to effect such a change in the personality that the symptoms cannot recur" (Horney, 1939a, p. 180).

JCO: Great. How do you accomplish such an impressive goal?

KDH: "Psychoanalysis embraces the whole personality, with all its calamities, and fears" (Horney, 1938, p. 213). "The goal of psychoanalysis is integration and unity" (Horney, 1991, p. 226). "The aim of therapy, then … is to restore the individual to himself, to help him regain his spontaneity and find his center of gravity in himself" (Horney, 1938, p. 215).

JCO: How do you decide where to focus?

KDH: "The neurotic personality is not a piecemeal conglomeration … but has a structure in which each part is intricately interrelated to each other part" (Horney, 1942, p. 172). "Psychic processes are as strictly determined as physical processes" (Horney, 1939a, p. 21). "Actions and feelings may be determined by unconscious motivations and that the motivations driving us

are emotional forces" (Horney, 1939a, p. 18). "Every trait develops because of inexorable necessity and serves a necessary function" (Horney, 1939c, p. 430). "In the center of psychic disturbances are unconscious strivings developed in order to cope with life despite fears, helplessness, and isolation. I have called them 'neurotic *trends*'" (Horney, 1942, p. 40).

JCO: I'm not familiar with the term 'neurotic trends'.

KDH: "Neurotic trends? … Their essential elements are unconscious" (Horney, 1942, p 40–41). "Neurotic trends … represent a way of life enforced by unfavorable conditions. The child must develop them in order to survive his insecurity, his fears, his loneliness" (Horney, 1942, p. 45). "Since the neurotic has more anxiety than the mentally healthy individual, he has to put an infinitely greater amount of energy into maintaining his security (Horney, 1939a, p. 73)." The aim of therapy is … to lessen his anxiety to such an extent that he can dispense with his 'neurotic trends'" (Horney, 1939a, p. 11).

JCO: So you try to improve the client's awareness of unconscious forces?

KDH: "My main objective in therapy is, after having recognized the neurotic trends, to discover in detail the functions they serve and the consequences they have on the patient's personality and on his life" (Horney, 1939a, p. 281). "After recognition of the neurotic trends … I primarily investigate their actual functions and their consequences" (Horney, 1939a, p. 282). "I would be interested primarily in understanding what this trend accomplishes for the individual" (Horney, 1939a, p. 281). "If he has, for example, a neurotic need for affection he will think that his is a good and loving disposition; or if he is in the grip of a neurotic perfectionism he will think that he is by nature more orderly and accurate than others" (Horney, 1942, pp. 41).

JCO: Do you interpret the client's struggles?

KDH: "A good interpretation means the unraveling of a knot or the elucidating a problem from which the patient has suffered" (Horney, 1936a, p. 36). "It entails bringing the patient to a thorough understanding of his conflicts – their general effect on his personality and their specific responsibility for his symptoms" (Horney, 1945a, p. 222). "Before terminating an analysis the patient should become less rigid, less vulnerable, less arrogant, more assertive, more warmhearted, more cooperative, more honest, more realistic" (Horney, 1946c, p. 237).

JCO: Do you help your clients to look for evidence for their beliefs?

KDH: "No, nothing of that sort" (Horney, 1980, p. 46). "This cannot be done by rational decision" (Horney, 1945a, p. 217). "Every neurotic … is averse to checking with evidence when it comes to his particular illusions about himself" (Horney, 1950b, p. 37). "The attempt to argue a neurotic out of his anxiety – the method of persuasion – is useless" (Horney, 1937, p. 44). "Evidence to the contrary … is discarded" (Horney, 1950a, p. 54). "The therapeutic task, therefore, can be only that of finding out the meaning certain situations have for him" (Horney, 1937, p. 44).

JCO: I feel it helps to show clients when their problems are driven by their own negative attitudes.

KDH: "I don't think that is right" (Horney, 1987a, p. 99). "The mere recognition

of a neurotic trend does not engender any radical change (Horney, 1942, p. 90). "We do not learn from our experiences … because we are too neurotic, too rigid" (Horney, 1947a, p. 85). "The capacity of the neurotic to recognize the consequences of his neurotic behavior and to learn from them is highly limited" (Horney, 1945a, p. 240). "He disregards evidence which he does not choose to see" (Horney, 1950a, p. 36).

JCO: I often encourage clients to hold a positive view but some people focus on their weaknesses and failures.

KDH: "A person builds up an idealized image of himself because he cannot tolerate himself as he actually is" (Horney, 1945a, p. 112). "The idealized image … although it exists only in the person's mind, it exerts a decisive influence on his relations with others" (Horney, 1945a, p. 108). "The idealized image substitutes for true self-confidence and pride" (Horney, 1945a, p. 101). "He cannot … develop his full potential unless he is truthful to himself; unless he is active and productive; unless he relates himself to others in the spirit of mutuality" (Horney, 1950c, p. 4).

JCO: But it helps to have a goal for self-improvement.

KDH: "If we want to be something we are not, without knowing it, we lose our self" (Horney, 1991, p. 223). "He was no longer interested in realistically tackling or outgrowing his difficulties, and in fulfilling his potentials, but was bent on actualizing his idealized self" (Horney, 1950a, p. 368). "In this very process he destroys himself, shifting his very best drive for self realization to the actualization of his idealized image and thereby wasting the potentialities he actually possesses" (Horney, 1950e, p. 420).

JCO: So therapy rejects a client's idealized view of self?

KDH: "Yes" (Horney, 1956a, p. 86). "The aim of psychoanalytic therapy is to help a person abandon his drive to actualize the idealized self and move towards self-realization" (Horney, 1956b, p. 25). "The more the phony self evaporates, the more the real self becomes invested with interest … to live as full a life as given circumstances permit" (Horney, 1942, p. 23). "The real self … is the alive, unique, personal center of ourselves; the only part that can, and wants to, grow" (Horney, 1950a, p. 155).

JCO: Where do you typically begin therapy?

KDH: "When he begins analysis, the patient as a rule is not interested in himself as he is. He is constantly concerned with what he should be and blames himself for his short-comings instead of tackling them realistically" (Horney, 1946a, p. 207). "The person creates in his imagination an idealized image of himself" (Horney, 1956b, p. 25). "The creation of the idealized self is possible only at the expense of truth about himself … The emphasis shifts from being to appearing" (Horney, 1950a, p. 38). "The individual has been a puffed-up balloon … but never himself" (Horney, 1939a, p. 289).

JCO: How do you help clients who hold with such a false view of self?

KDH: "The task of therapy, therefore, is to make the patient aware of his idealized image in all its detail" (Horney, 1945a, p. 114). "Caught in the wheels of neurotic processes we have to go through the purgatory of experiencing our inner dreads in order to find the path toward freedom and inner growth" (Horney, 1952c, p. 9).

JCO: You feel that an ideal view of self is destructive?

KDH: "Yes, of course" (Horney, 1980, p. 197). "The neurotic pursuits are almost a caricature of the human values they resemble (Horney, 1942, p. 62). "The patient had become a marionette, automatically doing, feeling and thinking what others expected of her" (Horney, 1939b, p. 130). "Self-idealization and glorification, while giving a feeling of importance, actually add to the inner uncertainty. They rob the neurotic of a solid base to stand on, alienate him from himself and – even worse – make him inevitably turn against his true self with hatred and contempt" (Horney, 1947b, p. 21). "Self-idealization inevitably grows into … the search for glory" (Horney, 1950a, p. 24).

JCO: What do you mean by 'the search for glory'?

KDH: "The mirage – the glory – which should end his distress is itself a product of imagination" (Horney, 1950b, p. 33). "The search for glory … is prompted by the impact of powerful needs" (Horney, 1950b, p. 34). "These needs are not instinctual but grow from the child's needs to cope with a difficult environment" (Horney, 1939a, p. 78).

JCO: Can you give me an example of a client's 'powerful needs'?

KDH: "The neurotic need for power" (Horney, 1942, p. 56); "the neurotic need for social recognition or prestige" (Horney, 1942, p. 58); "the neurotic need for personal achievement" (Horney, 1942, p. 58); "neurotic need for affection and approval" (Horney, 1942, p. 54). "There are a many people who demand a great deal of admiration and are grievously hurt if they do not receive it" (Horney, 1939b, p. 130). "A callous pursuit of self-interest is the paramount law … it implies using others for the attainment of one's goals" (Horney, 1945a, p. 64). "Any situation or relationship is looked at from the standpoint of 'What can I get out of it?' (Horney, 1945a, p. 65).

JCO: Isn't everyone a phony in some respects?

KDH: "This, however, is only true to some extent" (Horney, 1935b, p. 53). "The neurotic process … is a process of abandoning the real self for an idealized one; trying to actualize this pseudoself instead of our given human potentials" (Horney, 1950a, p. 376). "Demands on self, which, though understandable, are altogether too difficult and too rigid" (Horney, 1950a, p. 65). "The difference then, between healthy strivings and neurotic drives for glory, is one between spontaneity and compulsion; between recognizing and denying limitations" (Horney, 1950b, p. 38). "What I have described as the tyranny of the should … are an expression of the individual's unconscious drive to make himself over into something he is not" (a godlike, perfect being), and he hates himself for not being able to do so" (Horney, 1950e, p. 417).

JCO: One of my clients said her internalized voice had "malignant tendencies".

KDH: "I call them 'the tyranny of the should'" (Horney, 1950a, p. 65). "Any present shortcoming is unbearable for anybody harassed by dictatorial *should*" (Horney, 1950a, p 70). "The *should* have a coercive power. A person may function fairly well as long as he lives in accordance with his inner dictates" (Horney, 1950a, p. 75). "The *should* further impair the spontaneity of feelings, wishes, thoughts, and beliefs" (Horney, 1950a, p. 81). "The *shoulds* always contribute to disturbances in human relations" (Horney, 1950a, p. 81). "A person may primarily impose his

standards upon others and make relentless demands as to their perfection … The failure of others to do so arouses his contempt or anger" (Horney, 1950a, p. 78).

JCO: I love the phrase 'the tyranny of the should'. Can you give me some examples?

KDH: "He *should* be all things to all people; he *should* know everything better than anybody else; he *should* never err; he *should* never fail in anything he attempts to do" (Horney, 1950a, p. 76). "He *should* have had the inner strength and fortitude not to let these factors affect him (Horney, 1950a, p. 69). "He *should* be the utmost of honesty, generosity, considerateness, justice, dignity, courage, unselfishness. He *should* be the perfect lover, husband, teacher. He *should* be able to endure everything, *should* like everybody, *should* love his parents … nothing *should* matter to him, he *should* never feel hurt, and he *should* always be serene and unruffled. He *should* always enjoy life … He *should* be spontaneous; he *should* always control his feelings. He *should* know, understand, and foresee everything. He *should* be able solve every problem of his own, or of others, in no time. He *should* be able to overcome every difficulty of his own as soon as he sees it. He *should* never be tired or fall ill. He *should* always be able to find a job. He should be able to do things in one hour which can only be done in two to three hours" (Horney, 1950a, p. 65). "I suppose that this does not exhaust all the possibilities" (Horney, 1934b, p. 173).

JCO: Wow – that is quite a list! How do these *should* statements affect the client?

KDH: "The tyranny of the should drives him frantically to be something different from what he is or could be … abandoning the reservoir of spontaneous energies" (Horney, 1950a, p. 159). "The *shoulds* … put a person in a straight jacket and deprive him of inner freedom. Even if he manages to mold himself into a behavioristic perfection, he can do so only at the expense of his spontaneity and the authenticity of his feelings and beliefs" (Horney, 1950a, p. 118). "The *should* have a coercive power. A person may function fairly well as long as he lives in accordance with his inner dictates" (Horney, 1950a, p. 75). "The *should* further impair the spontaneity of feelings wishes, thoughts, and beliefs" (Horney, 1950a, p. 81).

JCO: Do *should* statements push the client to become the idealized version of himself?

KDH: "Yes, you are right" (Horney, 1980, p. 50). "The neurotic tries to actualize his ideal self" (Horney, 1950a, p. 64). "The more the drive to actualize his idealized self prevails in a person, the more the *should* become the motor force moving him, driving him, whipping him into action" (Horney, 1950a, p. 84). "He can relinquish the image only when the needs that have created it are considerably diminished" (Horney, 1945a, p. 114).

JCO: You have mentioned 'neurotic needs' and the 'tyranny of the should'. Is that it for red flags?

KDH: "But is it?" (Horney, 1942, p. 21). "The difference between spontaneous and compulsive is one between 'I want' and 'I must'" (Horney, 1950b, p. 31): "He *must* be the center of attention, he *must* be the most attractive, he *must* come out victorious in any argument, regardless of where the truth lies" (Horney, 1950a, p. 30).

JCO: It seems like the use of 'should', 'must' and 'need' statements are troublesome.

KDH: "What I mean is something far deeper" (Horney, 1967, p. 128). "I aim at the

individual's being able to dispense with his inner dictates altogether and to assume the direction of his life in accordance with his true wishes and beliefs" (Horney, 1950e, p. 418). "When we become aware that a person is driven by *shoulds*, we must ask, 'What particular things is this person demanding of himself?'" (Horney, 1956c, p. 200). "Thinking constructively means being aware of assets and shortcomings, always with the conviction that these shortcomings are neither fatal nor final … When an artist paints a picture, he presents what he considers essential in the landscape, omitting the irrelevant" (Horney, 1950d).

JCO: What about clients that struggle and fail to reach their goals?

KDH: "The realization of any present shortcomings is unbearable for anybody harassed by dictatorial should" (Horney, 1950a, p. 70). "What does it do to a person when he recognizes that he cannot measure up to his inner dictates? … he starts to hate and despise himself" (Horney, 1950a, p. 85). "The demands on self … constitute the individual's attempt to actualize his idealized image" (Horney, 1950a, p. 123). "The chasm between the idealized image and the actual self becomes unbridgeable. He feels beyond repair and beyond forgiveness. His hopelessness becomes deeper and he develops the recklessness of a person who has nothing to lose" (Horney, 1945a, p. 204). "By building his pedestal so high, by idealizing himself in such a fantastic way, by raising his standard to an impossible level, he is beginning to turn against himself as he really is. He begins to hate and despise himself the way he happens to be" (Horney, 1991, p. 222). "The patient may have seen in many instances that he feels others look down on him, while, in reality, it is he who despites himself" (Horney, 1948, p. 12). "The neurotic process … is a process of abandoning the real self for an idealized one' of trying to actualize his pseudo-self instead of our given human potentials" (Horney, 1950e, p. 419).

JCO: How can therapy reduce the tendency to idealize oneself?

KDH: "It is not easy" (Horney, 1945b, p. 137). "We must enter into his self-idealization and the irrational pride, should, claims, and self-hatred that it generates" (Horney, 1956c, p. 201). "The hatred … results from the discrepancy between what I would be and what I am" (Horney, 1950a, p. 114). "The more the drive to actualize his idealized self prevails in a person, the more they should become the sole motor force moving him" (Horney, 1950a, p. 84).

JCO: Creating an image of your own ideal self seems like it could provide helpful inspiration.

KDH: "I do not think this would be helpful (Horney, 1939a, p. 151). "The easy way to infinite glory is inevitably also the way to an inner hell of self-contempt and self-torment" (Horney, 1950a, p. 39). "It is best symbolized by the stories of the devil's pact" (Horney, 1950e, p. 418).

JCO: What do you mean by devil's pact?

KDH: "The neurotic is the Faust who is not satisfied with knowing a great deal, but has to know everything" (Horney, 1950b, p. 36). "When people sell their souls to the devil (that is when they sacrifice their real selves in the pursuit of glory), they are doomed to suffer inner torment" (Horney, 1947c, p. 242). "There are the promises of not only a miraculous riddance of distress, but of the possession of infinite power" (Horney,

1950e, p. 418). "The devil … tempts a person … with the offer of unlimited powers. But he can obtain these powers only on the condition of selling his soul" (Horney, 1950a, p. 39).

JCO: Do therapists need to watch for unrealistic expectations in themselves?

KDH: "Well of course, it is important to pay attention to that, too" (Horney, 1987c, p. 62). "I *should* always be understanding, sympathetic, and helpful" (Horney, 1950a, p. 67), "*should* be able to endure everything, to understand everything, to like everybody, to be always productive" (Horney, 1950a, pp. 64–65). "Sometimes the analyst can catch this process at the beginning and nip it in the bud (Horney, 1950a, p 71).

JCO: It sounds like comparing oneself to others can become a real problem.

KDH: "Yes" (Horney, 1956a, p. 86). "Neurosis … makes us too preoccupied with ourselves, whether we are aware of it or not" (Horney, 1947a, p. 85). "There is a constant measuring-up with others, even in situations which do not call for it" (Horney, 1936b, p. 222). "The neurotic constantly measures himself against others" (Horney, 1937, p. 188). "He constantly compares himself with other people, asking if they are cleverer or more attractive. This leads him to see others as rivals" (Horney, 1949b, p. 147). "We live in a competitive, individualistic culture" (Horney, 1936b, p. 227). "The evaluation of self is incisively influenced by … the evaluation of others (Horney, 1942, p. 65). "The reactions of neurotic persons are determined by an insatiable and irrational expectation that no one in the universe other than themselves *should* be intelligent, influential, attractive, or popular" (Horney, 1936b, pp. 222–223).

JCO: It seems natural to want approval from others. Why not support it?

KDH: "Why not?" (Horney, 1947a, p. 85). "The dependence upon the approval of everyone makes the neurotic extremely vulnerable, because if he feels rejected, or is rejected, then his falsely gained, spurious self-esteem drops immediately to zero" (Horney, 1950d). "Others can neither hurt nor establish self-esteem" (Horney, 1950a, p. 136).

JCO: So it's not really a search for approval but a fear of disapproval?

KDH: "Yes, of course" (Horney, 1980, p. 197). "The main factor that accounts for the fear of disapproval is the great discrepancy that exists between the façade which the neurotic shows both to the world and to himself and all the repressed tendencies that lie hidden behind the façade" (Horney, 1937, p. 239).

JCO: Can we help clients to realistically examine are their goals?

KDH: "Of course not" (Horney, 1950a, p. 68). "One simply cannot be unrealistic about oneself and remain entirely realistic in other respects" (Horney, 1950b, p. 33). "An intellectual realization, however, usually does not change much, if anything" (Horney, 1950a, p. 66). "If we tell a patient that he expects too much of himself, he will often recognize it without hesitation; he may even have been aware of it already. He will usually add … that it is better to expect too much of himself than too little" (Horney, 1950a, p. 65).

JCO: What happens if clients reach their goals?

KDH: "The neurotic does not gain what he most desperately needs: self-confidence and self-respect" (Horney, 1950a, p. 86). "The

neurotic is not proud of the human being he actually is" (Horney, 1950a, p. 90). "Self-contempt makes the neurotic hypersensitive to criticism and rejection" (Horney, 1950a, p. 134).

JCO: Do you focus on emotions in session?

KDH: "Working with our intellect alone … would be quite barren" (Horney, 1987c, p. 68). "The motivations for our attitudes and behavior lie in emotional forces" (Horney, 1939a, p. 23). "The patient must feel his conflicts, live with his self-contempt, experience how unrelated he is to anything" (Horney, 1952c, p. 6). "Reactions of panic, depression, despair, rage at self and others, to what is conceived as 'failure' are frequent – and entirely out of proportion to the actual importance of the occasion" (Horney, 1950b, p. 32). "Our reactions are thus determined not merely by the situation but even more by our neurotic needs" (Horney, 1950a, p. 97).

JCO: Some of my clients seem oblivious to their persistent emotional undercurrents.

KDH: "The neurotic often does not know or does not dare to know his own feelings" (Horney, 1947b, p. 22). "The more the emotions are checked, the more likely it is that emphasis will be placed upon intelligence" (Horney, 1945a, p. 85).

JCO: How do you help clients get in touch with their emotions?

KDH: "I encourage general awareness of feelings" (Horney, 1987a, p. 104). "Encourage the expression or the taking seriously of fleeting and abortive feelings" (Horney, 1987a, p. 103) "with the therapeutic aim of bringing patients back to themselves" (Horney, 1951b, p. 8). "As he frees himself from the prison of his neurosis, previously obscured emotions will be liberated" (Horney, 1956c, p. 204). "The patient needs encouragement to express whatever feelings come up and whenever they come up … whether his feelings are hopeful or discouraged, annoyed or irritated, cheerful, fatigued, anxious, interested, not interested, whatever" (Horney, 1987b, p. 41). "The more you encourage him and show interest in these feelings when they occur, the more he will respond by bringing something out" (Horney, 1987b, p. 50). "The person should try to express what he really feels and not what he is supposed to feel according to tradition or his own standards" (Horney, 1942, p. 248). "Pay attention to what he feels and when he feels it" (Horney, 1987b, p. 50). "When they arise, I can show the patient how little it serves his interests not to express his thoughts and feelings when they first come up" (Horney, 1987b, p. 42).

JCO: Do you feel it is useful for clients to express their emotions in session?

KDH: "The more anxiety is released by psychoanalysis, the more the patient becomes capable of affection and genuine tolerance for himself and others" (Horney, 1939a, p. 129). "Of course, I also feel it is important to avoid going overboard with the value of emotional experience" (Horney, 1987a, p. 99).

JCO: I've worked with some clients who seemed to be in a tragic, if not hopeless, situation.

KDH: "Hopelessness does not spring from a factually hopeless situation but constitutes a problem to be understood and eventually solved" (Horney, 1945a, p. 226). "A person may be so completely paralyzed by his hopelessness that moderate difficulties seem to him insurmountable" (Horney, 1945a, p. 182). "It is safer not to try than to

try and fail" (Horney, 1950a, p. 108). "The analyst must realize and explicitly convey to the patient that his situation is hopeless only so long as the status quo persists and is regarded as unchangeable" (Horney, 1945a, p. 186). "Human beings can apparently endure an amazing amount of misery as long as there is hope" (Horney, 1945a, p. 180).

JCO: This is somewhat related – I have found the Socratic method to be useful in therapy.

KDH: "The road of analytic therapy is an old one, advocated time and again throughout human history. In terms of Socrates … it is the road to reorientation through self-knowledge" (Horney, 1950a, p. 341). "It has always been regarded as not only valuable but also feasible to 'know oneself'" (Horney, 1942, p. 9). "One may ask whether one should really say with Socrates that the goal of analysis is to know yourself" (Horney, 1991, p. 224).

JCO: In your view, how does self-knowledge advance the goals of therapy?

KDH: "The aim of all analysis should be to help a person, through self-knowledge, to a reorientation in life, with a shift from self-idealization to self-realization" (Horney, 1950f, p. 278). "We want to help the patient to find himself, and with that the possibility of working toward his self-realization" (Horney, 1950a, p. 334). "The analyst's first aim, therefore, is to help the patient toward some measure of self-knowledge, toward some measure of inner relatedness to himself" (Horney, 1952c, p. 6). "The way toward this goal is an ever increasing awareness and understanding of ourselves. Self-knowledge, then, is not an aim in itself, but a means of liberating the forces of spontaneous growth" (Horney, 1950a, p. 15).

JCO: In what ways do people lack awareness?

KDH: "The concept of unconscious motivations has been generally accepted, but its implications are often not fully understood" (Horney, 1938, p. 209). "All of us have an interest in not being aware of certain feelings, drives, conflicts, qualities within ourselves" (Horney, 1952c, p. 3). "To thrust strivings out of awareness does not prevent them from existing and exerting an influence" (Horney, 1938, p. 209). "Simply repressing a drive usually does not suffice … to keep it in abeyance" (Horney, 1939a, p. 25).

JCO: Why would clients block out their memories or feelings?

KDH: "The patient has good reasons not to become aware of certain drives" (Horney, 1939a, p. 34). "We suppress feelings and strivings because we are vitally interested in not being aware of them" (Horney, 1938, p. 209). "Certain insights are not acceptable to the patient; they are too painful, too frightening, and they undermine illusions that he cherishes and is incapable or relinquishing (Horney, 1942, p. 139).

JCO: And you feel that repression is central to neurosis?

KDH: "The essential tendencies producing a neurotic conflict are deeply repressed (Horney, 1945a, p. 32). "Unconscious motivations remain unconscious because we are interested in not becoming aware of them" (Horney, 1939a, p. 21). "Repression means overcoming impulses by banishing them from our conscious mind" (Horney, 1933b, p. 31). "The process of repression can be compared to the ostrich policy: the repressed affect or impulse is as effective as it was before, but we 'pretend' that it does not exist" (Horney, 1939a, p. 25).

JCO: How does your therapy confront repressed conflicts?

KDH: "We have to uncover the causes of the resistance and to eliminate it" (Horney, 1968, p. 7). "We need to examine our unconscious motivations if it appears that something from within is hampering us in our pursuits" (Horney, 1942, p. 38). "Analysis involves uncovering infantile conflicts and fears that are still operating in the patient's life and recognizing the connections between these infantile sources and present difficulties" (Horney, 1933a, p. 116). "Fears and desires or entire experiences which are repressed in childhood … retain unaltered their intensity" (Horney, 1939a, p. 133). "Past emotional experiences tend to be repeated" (Horney, 1939a, p. 147).

JCO: How can the therapist be helpful with this?

KDH: "Reaching down to repressed material must stir up anxiety previously allayed by defensive measures" (Horney, 1942, p. 32). "The lifting of repression frees the way for action" (Horney, 1942, p. 113). "He will gradually have more energy available: the energy that had gone into repressing part of himself is released; he becomes less inhibited, less paralyzed by fears, self-contempt, and hopelessness" (Horney, 1945a, p. 238).

JCO: I am still confused. As a therapist, how do I help my clients?

KDH: "The neurotic must be helped … to become aware of his real feelings and wants, to evolve his own set of values, and to relate himself to others on the basis of his feelings and convictions" (Horney, 1945a, p. 220). "We may compare psychoanalysis with the excavation of a buried city, in which we assume the existence of valuable historical documents. According to the old method, we would be interested in these documents only and would dig in those places where we expect to find them. According to the new method, we would wish to uncover the whole settlement, i.e., the whole unconscious, and would remove layer upon layer of earth inside of the perimeter" (Horney, 1968, p. 4).

JCO: This sounds time consuming.

KDH: "Yes, you are right" (Horney, 1980, p. 50). "The most important therapeutic step is to bring the patient to see … the incapacitating effects of his neurotic drives and conflicts" (Horney, 1945a, p. 233); "only then will the patient actually feel the need of changing" (Horney, 1945a, pp. 233–234). "It is useless to confront a patient with any major conflict as long as he is bent on pursuing phantoms that to him mean salvation. He must first see that these pursuits are futile and interfere with his life" (Horney, 1945a, p. 223). "The ghost loses his power and vanishes if one has the courage to address him" (Horney, 1935b, p. 58).

JCO: I am not sure that a client's awareness is sufficient to produce positive change.

KDH: "I remember my own skepticism in the subject" (Horney, 1936a, p. 29). "Questions arise whether more knowledge about oneself necessarily changes anything … Self-knowledge per se is not enough" (Horney, 1950f, p. 278). "His knowledge of himself must not remain an intellectual knowledge, though it may start this way, but must become an emotional experience" (Horney, 1950a, p. 342). "Self-knowledge, then, is not an aim in itself, but a means of liberating the forces of spontaneous growth" (Horney, 1950a, p. 15). "In analysis, the actual healing forces lie in the patient himself" (Horney, 1991, p. 226).

JCO: If self-awareness comes first, where do things need to go after that?

KDH: "One of the goals of analytic therapy is the development of ability to assume real responsibility for one's self" (Horney, 1950g, p. 85). "He can grow only if he assumes responsibility for himself" (Horney, 1950a, p. 15). "The patient must acquire the capacity to assume responsibility for himself, in the sense of feeling himself the active, responsible force in his life, capable of making decisions and of taking the consequences" (Horney, 1945a, p. 241). "I (and nobody else) am responsible for what I think, feel, say do, decide" (Horney, 1947a, p. 86). "The patient will be less hostile when he sees his own share in the difficulty instead of externalizing" (Horney, 1945a, p. 238).

JCO: But many clients seem to avoid accepting responsibility for their problems.

KDH: "The patient may not feel himself at all an active factor in his own life. He lives as though his life were determined by outside forces" (Horney, 1951b, p. 8). "Chronic neurotics give the impression of having no say in their lives. They are driven by emotional forces which they do not know and over which they have no control. They cannot but act and react in rigid ways, often in contrast to their intellectual judgment" (Horney, 1939a, p. 185). "The unconscious argument, then, runs as follows: Others are responsible for the trouble I am in" (Horney, 1950a, p. 60). "If it were not for his wife, boss, lack of money, the weather, or the political situation he would be the happiest person in the world" (Horney, 1950a, p. 145). "If only I could find the right partner, I would be all right" (Horney, 1945b, p. 137).

JCO: What are your thoughts about the importance of self-awareness by the therapist?

KDH: "Knowledge of one's self, which Socrates thought important for healthy living, is a basic prerequisite for the analyst" (Horney, 1956d, p. 27). "Many people pride themselves on being realistic when actually they are merely peering through a cracked mirror of their own discontent" (Horney, 1950d). "As long as we have not found ourselves, how can we help others to find themselves? Only through finding and overcoming our own inner difficulties can we be productive" (Horney, 1946b, p. 67). "Your growth as a human being, however is a process that can and should go on as long as you live. Hence analysis as a means of gaining self-knowledge is intrinsically and interminably process" (Horney, 1946c, pp. 235-236).

JCO: It sounds like you recommend personal therapy for the therapist.

KDH: "Well, of course" (Horney, 1987c, p. 62). "Being analyzed oneself helps to mitigate blind spots … To make the observations accurately and to evaluate them correctly can be taught without it" (Horney, 1935a, p. 410). "You know, one of the great handicaps in our analytical work is our remaining personal neurotic difficulties" (Horney, 1987e, p. 17). "I am ridiculously shy, which has to be taken into consideration" (Horney, 1980, p. 220). "I want to conceal from myself and from others my feeling of inferiority" (Horney, 1980, p. 252). "The presence of these feelings of inferiority is one of the most common psychic disorders of our time and culture" (Horney, 1936b, p. 224).

JCO: Personal analysis for the therapist does not happen as often as it used to.

KDH: "Why not?" (Horney, 1947a, p. 85).

JCO: I'm not sure. It probably takes too long and costs too much.

KDH: "There is much reason for discontent with the effectiveness of our therapy" (Horney, 1987a, p. 15). "It is well known that a course of psychoanalytic treatment requires a long time" (Horney, 1968, p. 10). "While some of the experiments in brief psychotherapy are promising, many, unfortunately, are based upon wishful thinking and are carried on with an ignorance of the powerful forces that operate in neurosis" (Horney, 1945a, p. 240).

JCO: But long-term therapy can get expensive.

KDH: "It is hard on the patient to do psychoanalytic work if paying for the psychoanalysis makes even more difficult economic conditions that are too tight anyway" (Horney, 1956a, p. 89). "The cost of treatment is rather high, in keeping with the length of time spent on it by the doctor. Nevertheless, it seldom reaches that amounts that are habitually spent for hospitalization" (Horney, 1968, p. 10). "There is in my opinion but one sensible means to shorten analysis: to avoid a waste of time (Horney, 1939a, p. 304). "When the patient asks how long therapy will take, we can tell him it depends on his energy, honesty, and ability to reveal himself" (Horney, 1957b, p. 42). "He should realize clearly from the beginning how much the length and outcome of the analysis depend on his initiate, productivity, and cooperation" (Horney, 1946d, p. 12).

JCO: How would you describe the role of the therapist?

KDH: "The analysts cannot be altogether passive" (Horney, 1939a, p. 285). "We should follow the patient … steering him only occasionally" (Horney, 1957b, p. 40). "Analysis is a cooperative enterprise" (Horney, 1956d, p. 26). "It would be ideal if the analyst merely played the part of a guide on a difficult mountain tour, indicating which way would be profitable to take or avoid. To be accurate one should add that the analyst is a guide who is not too certain of the way himself, because though experienced in mountain climbing he has not yet climbed this particular mountain" (Horney, 1942, p. 14).

JCO: So the therapist leads, but leads where the client wants to go?

KDH: "This, I think, is a very difficult concept to grasp" (Horney, 1987b, p. 34). "It is directive, but not in the sense of 'directing'" (Horney, 1956a, p. 85). "To find a mountain path all by oneself gives a greater feeling of strength than to take a path that is shown, though the work put in is the same" (Horney, 1942, p. 36). "An analyst cannot bring the patient any further that the patient himself wants to go" (Horney, 1942, p. 19). "When I feel uncertain about a suggestion made to the patient, I point out its tentative character. If then my suggestion is not to the point, the fact that the patient feels that I too am searching for a solution may elicit his active collaboration" (Horney, 1939a, p. 287).

JCO: So a good therapist remains cautious?

KDH: "He has developed an attitude of realistic humility that allows him to be fully aware of his own limitations. Naturally he will express his opinion whenever it is clear to him that the patient is about to act against his own interest" (Horney, 1946a, p. 206). "The attitude is responsible to a large degree for the analyst's reluctance to give advice … He feels incapable of giving advice" (Horney, 1946a, p. 206). "You may sometimes, if you have doubts on this score, ask the patient a direct question" (Horney, 1987e, p. 101).

JCO: Sometimes I ask clients questions that my client cannot answer.

KDH: "The more important point here seems to be the fact of raising the question; once it has been put, answers suggest themselves almost spontaneously" (Horney, 1967, p. 39).

JCO: Novice therapists seem to want to solve problems for their clients.

KDH: "I do not think this would be helpful" (Horney, 1939a, p. 151). "Psychoanalysis in its very essence is cooperative work" (Horney, 1942, p. 138). "It is the goal of therapy to help a person to find his own self, to rediscover his own feelings, his wishes, what he really believes – to help him make his own decisions; for only if he finds himself has he a chance to grow and fulfill himself" (Horney, 1991, p. 223). "To find a mountain path all by oneself gives a greater feeling of strength that to take a path that is shown, though the work put in is the same and the result is the same" (Horney, 1942, p. 36). "The analyst cannot drag the patient through this process; the patient himself must want to go" (Horney, 1945a, p. 189).

JCO: So a good therapist helps clients to solve their own problems.

KDH: "This is true" (Horney, 1987b, p. 43). "It is certainly necessary to be aware of our goals lest we flounder aimlessly (Horney, 1946c, p. 256). "The analyst does not merely follow the patient. Through his interpretations, explanations, and questions, he influences the course of the analysis. He helps the patient out of blind alleys and suggests scrutiny along more profitable liens" (Horney, 1946a, pp. 208–209). "The analyst is not authoritative but endeavors to find out together with the patient in what manner he is blocking his own way" (Horney, 1946a, p. 205). "Of course, we are always glad to impart our knowledge, and that is all right up to a certain point" (Horney, 1987b, p. 48).

JCO: But sometimes clients make bad choices.

KDH: "The aim of analysis is not to render life devoid of risks and conflicts, but to enable the individual eventually to solve his problems himself" (Horney, 1939a, p. 305). "Analysis helps the patient to realize gradually that he is following the wrong path in expecting happiness to come to him from without, that that enjoyment of happiness is a faculty to be acquired from within (Horney, 1939a, p. 290). "By removing obstacles or by eliciting sufficient incentive, the patient's mental energy will be set to work and he will produce material that will eventually lead to some further insight" (Horney, 1942, p. 16).

JCO: It seems to me that the uncovering process can become emotional for some clients.

KDH: "The more we face our own conflicts and seek out our own solutions, the more inner freedom and strength we will gain" (Horney, 1945a, p. 27). "The patient who thus has gained some inner strength and some solid ground on which to stand is then ready to be confronted with his feeling of inner emptiness" (Horney, 1952c, p. 7).

JCO: Students seem to want structured manuals to guide their therapy.

KDH: "What is the reason for it?" (Horney, 1987a, pp. 92–93).

JCO: Novice therapists want guidance and instructions.

KDH: "The therapeutic process differs from case to case" (Horney, 1957a, p. 34). "The uniqueness of the analytic process itself makes … comparisons questionable" (Horney, 1957a, pp. 34–35). "The differences among people are too great to allow the pursuit of any prescribed path" (Horney,

1942, p. 95). "There is no blueprint to guide us" (Horney, 1946a, p. 193). "Because of the infinite individual variations … the analyst can sometimes proceed only by trial and error" (Horney, 1945a, p. 227).

JCO: What should I tell my students who want more structure?

KDH: "I can merely suggest that in your contacts with students you do everything in your power to impress upon the mind of each of them that he, as an individual, matters" (Horney, 1939b, p. 132). "Teach them that everyone should consult and express his own feelings and not blindly follow the leadership of others" (Horney, 1939b, p. 132). "Each patient is different, each complicated …But if we have an open minded and if our creative faculties do operate, many things will fall into place" (Horney, 1987c, p. 68).

JCO: There is also a push for sessions to take on an educational focus.

KDH: "I do not think this would be helpful (Horney, 1939a, p. 151). "We must avoid speaking to the patient in technical terms" (Horney, 1987b, p. 39). "What you tell the patient must always make sense and be meaningful" (Horney, 1987b, p. 40).

JCO: Let me shift topics a bit. In your opinion, how does someone become a skilled therapist?

KDH: "It is not easy" (Horney, 1945b, p. 137). "Nothing becomes as real to us as that which we directly experience" (Horney, 1987a, p. 91). "Little can be learnt either from text-books or from lectures, but only from personal clinical experiences" (Horney, 1927a, p. 258). "Technique can only be taught to a limited extent because ultimately technique depends on inner freedom, ingenuity, and finger-tip feelings" (Horney, 1987e, p. 17). "The intimate interrelationship of theory and practice makes it difficult to appreciate and understand one without the other" (Horney, 1968, p. 3).

JCO: What are your thoughts about the value of the therapeutic relationship?

KDH: "The doctor-patient relationship is of crucial importance" (Horney, 1956a, p. 86). "Psychotherapy provides a unique situation in which one human being confides in another without reservations and with a reasonable hope of being understood" (Horney, 1938a p. 212). "The essence of all human psychology resides in comprehending the processes operating in human relationships. The psychoanalytical relationship is a special one that provides us with unheard of possibilities for understanding these processes" (Horney, 1938, p. 212). "It is also the analyst's consistent interest in him as he is and as he could be that helps the patient to develop a constructive interest in his real self" (Horney, 1946a, p. 207). "The sensitive and understanding analyst will try unflaggingly to awaken the patient's numbed confidence in his own creative abilities" (Horney, 1956d, p. 31).

JCO: Do you still rely on transference as a therapeutic tool?

KDH: "Transference is the most powerful tool of analytic therapy" (Horney, 1938, p. 212). "The concept of transference … has become the most powerful, and indeed indispensable, tool of analytical therapy" (Horney, 1939a, pp. 33-34). "In each human relationship, there is the possibility of mutual influence" (Horney, 1956a, p. 88). "His relationship with the analyst … is a human relationship, and all the difficulties the patient has with regard to other people operate here too" (Horney, 1950a, p. 339).

JCO: But today, sessions are usually conducted once a week, diluting the transference relationship.

KDH: "Is this true?" (Horney, 1939a, p. 143). "Much of the future of psychoanalysis depends on a more accurate observation and a deeper understanding of the patient's transference reactions" (Horney, 1938, p. 212). "Our understanding of a patient will be incomplete if we do not enter into his feelings and live through them with him … We must know what the patient is experiencing and not simply know about it. It is like the difference between 'being in jail' and 'reading of being in jail'" (Horney, 1956c, p. 201).

JCO: In your approach, empathy is key?

KDH: "Yes, of course" (Horney, 1980, p. 197). "A symptom cannot be understood unless one enters more deeply into the personality" (Horney, 1991, p. 220). "The patient has all the raw data. He has lived with himself. And this is what he brings to the cooperative enterprise of psychoanalysis … the patient is the one who really knows" (Horney, 1987b, p. 40).

JCO: Do you respect an integrative approach to therapy?

KDH: "Does it make any practical difference in therapy whether the analyst adheres to this or that school of thought?" (Horney, 1946d, p. 11). "I don't believe that" (Horney, 1980, p. 66). "It seems to me an advantage to learn other psychotherapeutic methods, not only in order to mix them on occasion with the 'pure gold of analysis', but to be able to judge what other possibilities there are for any special case" (Horney, 1927, p. 258). "Sometimes one cannot ward off an impression that we analysts fall victim to too much theorizing" (Horney, 1927, p. 257). "I am quite sure that two different analysts … listening to the productions of the same patient in one hour, may have very different impressions" (Horney, 1987e, p. 28).

JCO: I see myself as an outsider to traditional psychoanalysis.

KDH: "As an outsider with a certain experience and training, you are more likely to have a greater perspective on whatever the patient will tell you, more than the patient himself" (Horney, 1987b, p. 40). "This brings me to the end of my remarks" (Horney, 1967, p. 52). "I would like to conclude at this point" (Horney, 1967, p. 130). "I believe a general emotional fatigue has taken over in me" (Horney, 1980, p. 228).

JCO: Thank you for your time and for your valuable contributions to the field of psychotherapy.

Discussion

As a practicing clinician with 40 years of experience providing psychotherapy to a mix of adult psychiatric patients, I find great value in Dr. Horney's words of advice. I appreciate the value of a cognitive-behavioral approach, but I also see its limitations. Reading the published works of Dr. Horney has helped to expand my view and refine my approach to psychotherapy. Many clients struggle with anxiety and depression that appears related to their tendency for social comparisons and their frequent use of "should" statements. Clients often struggle with chronic interpersonal problems related to their tendency to move away from or move against the people in their lives. It was useful to review Dr. Horney's work, many of which had been published 75 years ago, and appreciate the commonalities with contemporary clinical practice.

I was motivated to write this article because I worry that her work will be neglected and overlooked. For the past four decades, I have been teaching psychotherapy at both the graduate and undergraduate levels. Undergraduate courses in psychology may briefly describe Horney's work about personality theories without explaining her influence on the field of psychotherapy. In graduate courses, Dr. Horney's work may be omitted entirely. In the U.S., most young professionals today focus heavily on cognitive-behavioral approaches, with little appreciation for the historical pioneers of our field. The field of psychotherapy needs to respect the path that was laid out by the pioneers in the field, recognizing some of their key insights that remain essential to contemporary psychotherapy.

My interest in interviewing the experts in psychotherapy began when I met with Albert Ellis (Overholser, 2003), and later enjoyed a conversation with Irv Yalom (Overholser, 2005). Although I was disappointed to miss opportunities to talk with other pioneers, I experimented with a format for simulated interviews with some of the pioneers who were no longer available for an actual meeting. I was aware of the important works published by Karen Horney, but it had been many years since I had read her books or articles in depth. I began working on this paper several years ago. I was excited to learn the details about her life, her career, and her views on psychotherapy. While preparing this simulated interview, I was careful to represent her ideas without forcing her words into my own beliefs and values. Although the material has been filtered through my own perspective, I hope that I was able to channel many of her ideas, her struggles and her innovations into the simulated interview. I hope this article inspires others to read her original writings and respect the ideas that Dr. Horney published many years ago.

> Note: Some citations have titles that overlap because reprinted versions occasionally use slightly different phrasing in key sections of the text. Some of these subtle differences arise from translations from her native language, German. Other differences arise from prior attempts to compile assorted sources into a coherent book chapter.

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Positivism's Rise, Dominance & Impact. A Discussion with Focus on Psychotherapy Research and Psychotherapies

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Abstract: My main focus is on positivism, its rise, and methodological dominance in psychotherapy research but with particular emphasis on psychoanalysis. By situating positivism in historical contexts and illuminating unconscious processes, possible reasons for positivism's initial rise as a philosophy and methodology, its historical dominance, and contemporary monopoly via the quantitative paradigm are provided. An interplay of various defensive maneuvers is suggested. Positivism may serve as protection against death anxiety and existential fears, or it may function as an ideology or as an idealized part-object. Critical thinking could be hampered by unconscious processes. Many people may need the positive ideal of methodological positivism, because it allows them to cope with their own mortality. Additionally, the epistemic consequences of the positivistic dominance on research, psychotherapies, and on non-positivistic knowledge are explicated. This includes a brief discussion of epistemic oppression, philosophical racism, and the imbalance in psychotherapy research.

Keywords: Positivism, Quantitative Paradigm, Psychoanalysis, Psychotherapy Research, Methodological Dominance

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Introduction

For clinical, ethical, epistemological, and institutional reasons, research is important for all psychotherapists (Fonagy, 2003). This importance is reflected in guidelines. Professional bodies, such as, the British Association for Counselling and Psychotherapy (BACP), the United Kingdom Council for Psychotherapy (UKCP), and the American Psychological Association (Cuttler et al., 2021), require professionals to evaluate interventions critically. Psychotherapists should be able to explain to clients, employers, and the wider community which psychotherapies are effective and recommend alternative treatments (McKean et al., 2021). So, psychotherapists must be familiar with outcome/intervention studies, quantitative methods (Vossler & Moller, 2015), and their underlying philosophies (Vosmer, 2025).

Nowadays, this is easier said than done because of the plethora of methods. Due to the rapid increase of digital mental health (telehealth, mental health apps, digital therapeutics), vast amounts of psychotherapy outcome data are collected via the Therapy Outcome Management System App (see Löchner et al., 2025). Analyses of these data require the use of the big data method. It is primarily a *quantitative* tool, which includes advanced analytics, machine learning, and data mining techniques, which are used to extract insights from complex datasets (Thelwall & Nevill, 2021).

The question of whether psychotherapy (research) must be, or is now, more scientific (Young, 2021), depends on the view one takes. Proponents of the *scientific method*, which is philosophically underpinned by positivism, may think so and conduct *empirical* studies to evidence that a certain type of psychotherapy is 'empirically supported'. Essentially, this means that it has been shown to be efficacious under controlled conditions (Chambless & Hollon, 1998, p. 7) and causal relationships have been determined (Di Nuovo, 2019). The criteria for effectiveness studies are less stringent than for efficacy studies. The former utilize less standardized treatment protocols and more heterogenous client populations, because they study a clinical intervention under real-life rather than ideal conditions, in contrast to efficacy studies (Fritz & Cleland, 2003).

Empirically proven psychotherapies have mistakenly been equated with evidence-based practice (EBP) (Kendal & Frank, 2018), which emerged in the 1990s (Evans & Benefield, 2001). Heavily criticized by several psychotherapists (Abe et al., 2018; Dalal, 2018), EBP nonetheless dominates the clinical landscape (DuBois, 2020). It refers to the integration of the best available research evidence and clinical expertise, whilst considering client characteristics and culture (APA, 2016). Culture is defined by Frie (2014) as an inherently dynamic, participatory, and interactive process encompassing language, tradition, and heritage, which are passed down across generations (p. 390).

The quantitative (nomothetic) paradigm is often equated with science (Park et al., 2020), because the quantitative approach implies a positivist research paradigm (Maksimovic & Evtimov, 2023). Traditionally, the philosophies of positivism, interpretivism, and critical theory guided research methods and analysis (Ryan, 2018). From the 1960s onward, positivism began to dominate psychology, behaviorism (Gabriel, 2023), and cognitive behavioral therapy (CBT) through operationalism, i.e., defining concepts in terms of specific operations to measure them (Dalal, 2018). Positivism's contemporary relevance, according to Hasan et al. (2024),

is due to its ability to produce quantifiable data, as well as valid, reliable, and applicable knowledge. This is reflected in expectations of services (Vossler & Moller, 2015) that psychotherapists engage in quantitative research activities, such as, *measuring* the outcome of sessions through questionnaires (Låver et al., 2024). Measurement is quantitative. Both science and EBP give precedence to measurable data, which is echoed in the practice guidelines of the American Psychiatric Association (Silverman et al., 2015) and the American Psychological Association (Cuttler et al., 2021).

Recently, the term 'research culture' has gained prominence and Science Europe (2024) adopts the definition of the British Royal Society (2025a, para. 2, ff.): Research culture encompasses the behaviors, values, expectations, attitudes, and norms of research communities. It determines how research is conducted and communicated. Commonly, empiricism, which comprises the use of experimentation or observation (APA Dictionary of Psychology, 2018), and randomized controlled trials (RCTs) are favored. While intervention studies can be placed on a continuum, with a progression from efficacy to effectiveness trials, the RCT method is used in both (Singal et al., 2014). Even though 'best research evidence' comprises several methods (Cook et al., 2017), including clinical observation, the data from efficacy and effectiveness studies are given more weight.

Looking at it from a sociocultural perspective, people are psychological beings, who are constituted by culture and always participate in its process (Frie, 2014). This means that researchers and psychotherapists are molded by, and take part in the formation of, their research culture. Currently, the prevailing research culture in psychotherapy seems more positivistic than hermeneutic (interpretivist). This is noticeable in the increasing number of RCTs (Rief et al., 2022) due to the prioritization of both EBP (Cowen et al., 2017) and the 'hierarchy of evidence', a pyramid which orders evidence in terms of its importance. Meta-analyses, systematic reviews, and RCTs are at the top, considered to provide the strongest evidence (Murad et al., 2016). Whether the pyramid will be replaced by the recently developed dimensional framework (see Rohfing et al., 2025) remains to be seen.

Gelo et al.'s (2020) systematic review shows that the methodological practice of psychotherapy is dominated by a scientific monism that has led to a quantitative monopoly. Tellingly, the British Royal Society (2025b) is dedicated to helping the wider public understand the *scientific method*. It entails objectively establishing facts through observation, forming a hypothesis, making a prediction, conducting an experiment, and analyzing the results (Wright, 2023).

The requirement to approach research scientifically is more difficult to meet when researching psychodynamic or group analytic psychotherapies, because they are not normally manualized. Thus, the majority of efficacious psychotherapies are cognitive-behavioral (Emmelkamp et al., 2014). Individual CBT, which involves helping clients modify their maladaptive thinking patterns (Beck & Haigh, 2014), is the dominant treatment in Britain (Clark, 2018). Due to compelling empirical evidence for its efficacy (David et al., 2018), CBT is frequently recommended by the World Health Organization (WHO, 2025) and by the British National Institute for Health and Care Excellence (NICE), which provides guidance on the type of treatment that should be offered (see Dawoud et al., 2022). Psychodynamic psychotherapy, which

is an effective treatment for several disorders (see Leichsenring et al., 2024; Yarns et al., 2026), is less frequently recommended. It involves an exploration of unconscious aspects of the Self (Shedler, 2010), the resolution of internal conflicts that are rooted in childhood and changing one's unhelpful patterns of relating (Abrahams & Rohleder, 2021).

Undoubtedly, evidence is a matter of concern in many healthcare systems (Goldenberg, 2006). What counts as evidence is, however, hotly debated. A difference in opinion is often rooted in researchers' differing epistemological and ontological beliefs (Bruun, 2024). Ontology seeks to explain reality (Varzi, 2011). Epistemology concerns itself with knowledge, its nature, scope, and origin (Nobus & Quinn, 2013).

Solms (2018) rebuts the notion that psychoanalysis is not evidence-based. Psychoanalysis, the domain of the unconscious (Eisold, 1995), was the first psychotherapy, and Foulkes' (1964) group analysis has integrated some of its theories. Vosmer (2021) suggests that there are more positivistic aspects in the Freudian dynamic unconscious and in group analysis than is commonly acknowledged. Group analysis, like cultural psychoanalysis (see Frie, 2014), postulates that cultural and historical contexts indelibly constitute people. Nowadays, the term 'psychoanalysis' refers to a group of psychotherapies of the mind (psychodynamic therapies), a method of psychotherapy, and to the observation of mental functioning (Grant & Harari, 2005, p. 446).

Some psychodynamic researchers have adopted operationalism (Stamenova & Hinshelwood, 2018). By focusing on the conversion of theoretical concepts into objectively measurable constructs, operationalism discards subjectivity, Dalal (2018) argues. Operationalism can create other problems if inappropriately used in psychotherapy research, i.e., when the underlying philosophical assumptions of a project are incompatible (Green, 1992, 2001). If psychotherapy researchers cannot defend their epistemological and ontological assumptions, their studies may rest on "philosophical quicksand" (Green, 1992, p. 292).

Considering how crucial the quantitative paradigm is for psychotherapy research one would think that psychotherapists acquire a good understanding of philosophical positivism during their training. However, a recent study on global psychotherapy training programs (Orlinksky et al., 2024) does not even mention that positivism is taught. When looking at guidelines, there is no requirement to teach the philosophy of positivism to psychotherapists registered with the Council of Psychoanalysis and Jungian Analysis (CPJA), whose organizations are accredited by the UKCP (see UKCP, 2018). Even though the British Psychoanalytic Council's (BCP) Research Advisory Group recognizes the necessity that psychotherapists gain an understanding of research in order to ground the psychoanalytic practice on a firm empirical base, it does not refer to positivism (see Scott, n. d). Neither do the new Standards of Conduct, Practice and Ethics (BPC, 2024), which only outline a few duties regarding clinical research. Interestingly, the American Psychoanalytic Association (APsA), which is an affiliate of the American Association for the Advancement of Science, includes "Scientific Responsibility" in its Code of Ethics (APsA, 2024a, p. 13). Other than noting on its website that some training institutes offer research-oriented psychoanalytic training programs, the focus appears to be on applied research rather than on teaching research philosophies (see APsA, 2024b). The

European Group Analytic Training Institutions Network (EGATIN, 2021, 2024) does not even mention research in their Code of Practice for Organizations or in their Essential Training Standards in Group Analytic Psychotherapy. Whilst students on doctoral programs learn about philosophical research traditions, it is questionable that trainees on non-university-based (psychoanalytic) psychotherapy training programs do. Thus, one cannot assume that the latter have a good enough understanding of positivism. Some may have only superficially grasped the tensions surrounding positivism. Others may lack an understanding of the complexity of positivistic assumptions, or they may embrace positivistic claims without even recognizing that they do. Several psychotherapists may be perturbed by the scientific monism in psychotherapy research (Gelo et al., 2020) but may fail to see the connection to seemingly antiquated philosophies from the 19th and 20th centuries. Or they may not realize how positivism impacts on psychotherapy research and psychotherapies. Readers of the extant literature may also be forgiven for feeling confused, because the word 'positivism' has different meanings. For example, it refers to the commitment to developing sociality (Paley et al., 2008), the articulated philosophical tradition of logical positivism/logical empiricism (Uebel & Limbeck-Lilienau, 2023), and the quantitative research practice (methodological positivism) (Alvesson & Skőldberg, 2009). Psychotherapy researchers and psychotherapists commonly think of 'research practice' when referring to positivism (Riley, 2007).

I will use 'positivism' as an umbrella term for all schools of positivism (Comte's positivism, logical positivism, logical empiricism, post-positivism (Popper), and neo-positivism). This is justifiable, because these schools are similar in their adherence to scientific methodologies and search for objective truth (Houghton, 2011). To avoid confusion, I will use the terms 'methodological' and 'epistemological' positivism when referring to the quantitative paradigm or to research practices. Additionally, since psychoanalysis was the first psychotherapy (Vosmer, 2025), I will focus more on psychodynamic and group analytic psychotherapies in this article, which is structured as follows:

In Section 1, I will outline features of positivism and describe criticism directed at it. Possible reasons for its rise and dominance will be suggested. By situating positivism in historical contexts and illuminating unconscious processes, I will provide possible explanations for its rise as a philosophy and its methodological monopoly. In Section 2, I will critically discuss consequences of positivism's epistemological dominance for research, psychotherapies, and for non-positivistic knowledge traditions. I will include a brief discussion of epistemic oppression, philosophical racism, and the imbalance in psychotherapy research.

1. Philosophical & Methodological Positivism

1.1. The Philosophies of Positivism

Positivism is a family of philosophies that views science extremely positively (New World Encyclopedia, 2022). Many positivists believed that scientific methods would reform philosophy and society. Logical positivists, such as Carnap (1963), wanted to improve society, because they were convinced that their cultures were incapable of developing measures to deal with politico-economic disasters (Pearson, 2018). History proved them right. After the Great Depression in 1928, fascism spread rapidly in Germany, partly due to high inflation and

unemployment. Subsequent economic crises also led to suffering and misery.

As an intellectual and cultural movement, positivism was powerful (Sobayi, 2021). Positivism, which was introduced by the French philosopher Comte in the early 19th century, holds that knowledge is derived from sensory experience and observation. During the 1920s, it was further developed in Austria (Max Schlick, logical positivism) and in Germany (Hans Reichenbach, logical empiricism) (Rubinstein, 2005). Logical positivists/empiricists prioritized mathematics, inductive logic, observation, verification, and measurement. Tellingly, Carnap (1958) insisted that people were enslaved by metaphysical ways of thinking. So, he argued for the use of scientific methods and a scientific articulation of philosophy, i.e., the Philosophy of Science. (Logical) positivists rejected both idealism (the view that ideas/concepts are the essence of knowledge and reality) and rationalism (the view that knowledge and reality are understood by reason). They aimed to uncover the truth, hence, only objectivity mattered. Post-positivism is characterized by more flexible views on objectivity (Maksimovic & Evtimov, 2023).

Positivism holds that our social world operates according to the same general laws as the physical world, so, it aims to establish causal laws (Popper, 1934, 1962). It focuses on epistemology (Riley, 2007). As such, *phenomenalism* (only knowledge confirmed by the sciences is genuine knowledge), *deductivism* (theory generates hypotheses that can be tested for provable laws), *objectivity* (science must be value-free), and *inductivism* (knowledge is gained by gathering facts that provide the basis for laws) are crucial aspects of positivism (Bryman, 2008). Neo-positivism claims to produce objective knowledge (Scott & Marshall, 2015), which can be formulated as mathematical formulas that express functional relationships (Ponterotto, 2005). All these specific epistemological assumptions determine the overarching philosophical orientation of a quantitative research project (Nobus & Quinn, 2013).

1.2. Crucial Features of the Quantitative Paradigm

A paradigm is a set of accepted assumptions/theories among a scientific community, which explains a phenomenon (Kuhn, 1962). Establishing cause-and-effect relationships and interrogating/verifying existing theories constitute the basis of the nomothetic paradigm (Maksimovic & Evtimov, 2023). With its emphasis on objectivism, the pillars of the quantitative paradigm are observation, deductive logic, experimentation, and statistics (Park et al., 2020). Allmark and Machaczek (2018) explain that post-positivists embraced the notion of fallibility, e.g., theory ought to change if the data do not support it. Post-positivists value formulating a substantive theory (developing, testing, refining a theory if necessary), and positivists valued testing hypothesis from existing theories (Tenny et al., 2022). Whereas statistical techniques enable researchers to predict and manipulate variables, statistical analyses are not without flaws (Dalal, 2015, 2023; Jackson, 2020), and methodological positivism is controversial in psychotherapy and other research (see e.g., Shean, 2013; Franz, 2023; Nilsen, 2023).

1.3. Positivism's Dubious Ontological & Epistemological Premise

Positivism resulted from foundationalism (Ryan, 2018). It adopted Hume's theory of the nature of reality, i.e., reality consists of atomistic (micro-level) and independent events, according to Kaboub (2008). Believing in the

use of the senses to generate knowledge about reality, Hume argued that philosophical and logical reasoning could lead us to "see" non-existing connections between simultaneously occurring events (p. 343). Positivism's theory of knowledge also adopted Descartes' theory, who believed that reason was the best method to produce knowledge (Kaboub, 2008). However, Descartes' deductive method implies that events are ordered and interconnected, so, reality is ordered and deducible. Since Hume's and Descartes' theories differ, Kaboub concluded that positivism failed as a coherent philosophy of science due to the inconsistency between its theory of 'reality' and 'knowledge'. Perhaps this is not surprising, because positivism did not concern itself much with ontology and was mainly focusing on epistemology.

Lacan (1965) argued that the simultaneous pursuit of knowledge and the disavowal of its truth characterize the subject of modern science. In my reading, this means the following: By demanding that the methods (RCTs) and objects of knowledge (sensory experience) provide us with certainty and truth, modern science has progressively reduced truth to knowledge (ontology to epistemology). Positivism appears to have done this. However, since this truth is located inside knowledge, the modern Cartesian split between knowledge and truth is erased (Shah, 2017). Consequently, knowledge equals truth. We notice this in positivism, which is predicated on the Correspondence Theory of Truth, which states that d is true, only if d is consistent with reality. More troubling is the idea that truth corresponds with an objective reality (Mondal, 2023). Although post-positivists use the notion of fallibility (fallibilism), acknowledging that completely true accounts of the social world can never be obtained, since scientific knowledge is potentially fallible (Popper, 1962), ultimately, they want to show what lies underneath sensory experience (Allmark & Machaczek, 2018). Thus, data derived from the senses are still regarded as the source and endpoint of all knowledge, and researchers use established frameworks through which sensory experiences are interpreted.

1.4. Positivism & Psychoanalysis

There is a long-standing tension between modern psychoanalysis and positivism. While the former accepts transference phenomena and subjective experiences as evidence, the latter vehemently rejects them. Historically, many heated debates about the scientific status of psychoanalysis occurred in the 20th century (e.g., Grünbaum, 1984, 1986; Popper, 1962). Although Freud (1895) viewed his psychoanalysis as scientific, positivists dismissed psychoanalysis due to its unscientific concepts/theories (the dynamic unconscious cannot be measured/falsified). The post-positivist Popper (1962) equated the ego, id, and superego to myths. However, Grant and Harari (2005) argued that Popper's (1934) falsification criterium and rejection of psychoanalysis as a science were too simplistic.

Even nowadays, few topics elicit as much controversy as the role of empirical research in psychoanalysis (see Luyten et al., 2006, for an overview; Marogna et al., 2025, for a review). This has resulted in cultural clashes. While one group insists that the focus should be on meaning, interpretation, and narration (hermeneutic approach influenced by French psychoanalysis), others (influenced by anglophone psychoanalysis) adopt a modern, neo-positivist stance, arguing for the use of quasi-experimental and experimental methods (Luyten et al., 2006). Interestingly, even psychoanalytic schools that oppose a positivistic position, according to Hoffman (1991), may nevertheless end

up adopting a positivist stance. Although few researchers address the epistemological position of psychoanalysis, Bion explicated his epistemological stance by drawing on Kant and formulating a psychological theory of thinking (Stanicke et al., 2020), which I will expand on, as I procced.

Metaphysics attempts to establish the structure of reality underlying the totality of being (Horkheimer, 1999). Positivism's dismissal of metaphysics is problematic from a Freudian psychoanalytic perspective, because Freud's theory of reality includes a metaphysical aspect about the relation between psychic and external reality (Casey, 1972).

Whereas Freud (1895) regarded his method (psychoanalysis) as scientific, psychoanalysis is more commonly associated with hermeneutics, which is the theory of interpretation (Gadamer, 1976) and interpretivism. In contrast to positivist researchers, interpretivists tend to eschew causal analysis (Lawler & Waldner, 2023). Instead, they contextualize and focus on achieving a deep understanding of people, histories, culture, and so forth (see Lincoln & Guba, 1985; Guba & Lincoln, 2005). Interestingly, in his case studies (e.g., Freud, 1905), Freud, like other early psychoanalysts, wished to establish causation by interpreting and analyzing a client's feelings, motivations, actions, relational communication, and use of language/gestures. However, the 'case study' is a qualitative method (Alpi & Evans, 2019; Råbu & Binder, 2025). Therefore, it cannot evidence causation and should not be confused with the 'single-case experimental design' (Fingerhut et al., 2023).

1.5. Interpretivist's Criticism of Positivism

Philosophically, interpretivism can be traced to Hegel, Heidegger, Gadamer, and Habermas (Lawler & Waldner, 2023). Habermas is one of the founders of the Frankfurt School, where critical theory stems from, which considers the wider oppressive nature of politics or societal influences, and often includes feminist research (Ryan, 2018). The research tradition of interpretivism arose in opposition to positivism, although Lawler and Waldner (2023) have identified implicit causal explanations in the findings of some interpretivists. Arguing to replace an outdated positivism with 'inferentialism', Lawler and Waldner suggest that the use of the interpretive method is often justified through the critique of positivism. Interpretivists reject positivism's empirical and predictive claims (see Gadamer, 1976, 1979). They see the goal of theorizing as providing an understanding of direct lived experience rather than offering abstract generalizations (Lawler & Waldner, 2023). Interpretivists value subjectivity (Ryan, 2018) and may employ hermeneutical methods, including interpretative phenomenological analysis (Smith et al., 2022).

1.6. Further Criticisms Directed at Positivism

Positivism aims to prove that phenomena from the social sciences/humanities can be equally measured as natural phenomena. In addition to having been criticized by *post-positivists* (reject that total objectivity is possible, Maksimovic & Evtimov, 2023; Popper, 1934, 1962 showed that logical positivists failed to satisfy their own verification principle), it has numerous *other critics*:

feminists (Eagly & Riger, 2014, criticizing positivism's androcentric bias),

qualitative researchers (Creswell, 2002, experiences/meaning are ignored),

post-colonial scholars (Chakrabarty, 1992, positivism ignores the majority of mankind; tool of imperialism),

post-modernists and post-structuralists (Baudrillard: images/representations have no referents in the real world, see van Kassel et al., 2025; Foucault, 2020, knowledge is molded by history and power; scientific knowledge silences/marginalizes certain experiences),

other social scientists (e.g., Riley, 2007),

philosophers (Husserl: logical positivism's conceptualization of the acquisition of knowledge necessitates acceptance of a deterministic hegemony of thinking; philosophy lost its reflective core due to positivism, Coole, 2001),

and *psychotherapists* (Dalal, 2018, methods cannot capture the intricacies of human exchange in psychotherapy).

Furthermore, positivism is reductionist, asserting that social processes can be reduced to relationships between individuals or the actions of individuals (see Sobayi, 2021). Applying the positivist research paradigm to psychotherapy is problematic, because, as Negri et al. (2019) argue, people or relationships cannot be isolated without destroying their wholeness. Most troubling for psychotherapy research is their argument that the same intervention can be appropriate and effective at one point, but ineffective or even injurious at other times (Negri et al., 2019).

1.7. Why the Need for Explanations of Positivism's Rise & Dominance?

Despite the criticisms that have been directed at methodological positivism, it still dominates psychological (see Breen & Darlaston-Jones, 2010) and psychotherapy research (see Negri et al., 2019). RCTs remain the gold standard and essential building block of mental health research (Harrer et al., 2023), and CBT researchers use the RCT method frequently. Gelo et al.'s (2020) systematic review identified a scientific monism in psychotherapy research. So, it is established that quantitative methods and, therefore, methodological positivism dominates. The questions that remain unanswered are 1) why philosophical/methodological positivism began to dominate disciplines; 2) why methodological positivism continues to dominate psychotherapy research; 3) what the consequences of this dominance are.

I will address these questions from different perspectives to provide possible explanations. Before doing so, I must clarify a few points. Firstly, Gelo et al. (2020) proposed the lack of critical thinking and science as reasons for the quantitative monology. I will elaborate on this from a psychoanalytic/group analytic perspective, additionally drawing on Freud (1921), Foulkes (1964), and Bion (1961, 1962a, b), who postulated that individuals or groups are constituted and influenced by unconscious processes, to provide possible explanations for positivism's rise and the quantitative monopoly.

Secondly, I do *not* intend to systematically explicate the unconscious (social) influences and their manifestations in philosophy, research, and clinical practice. This would include identifying the workings of the social unconscious, which would be a piece of research in its own right. Suffice it to say that the social unconscious is broader than the Freudian dynamic unconscious, and Brown (2001) explained how to identify its manifestation. Hopper (2001) defines it as

> "… the existence and constraints of social, cultural and communicational arrangements of which people are unaware; unaware, in so far as these arrangements are not perceived (not known), and if perceived not acknowledged (denied), and if acknowledged, not taken as problematic ("given"), and if taken as problematic, not considered with an optimal degree of detachment and objectivity." (p. 10)

Thirdly, although history, and particularly Bion's, Lacan's (1965), Žižek's (e.g., 1993), Dalal's (2011), and Hopper's (1996) work are important to my argument on ideology and trauma, space does not allow me to go into much detail.

1.8. Possible Explanations for Positivism's Rise, Splits & Spreading

Here, I will briefly attend to positivism's rise, the split into different variants of positivism, and how it spread, by looking at historical events. Agreeing with Frie (2014) that the past influences the present, and with Dalal (2001) that history unconsciously influences people, I believe that contextualizing philosophical and methodological positivism historically is important. I will interweave psychoanalytic and group analytic interpretations.

1.8.1 Historical Contexts

The intellectual movement in the 17th and 18th centuries (Enlightenment) can be characterized as the process of becoming progressively self-directed in both thought and action through the awakening of one's intellectual powers. The prioritization of rationality and science superseded beliefs in the supernatural (see Bristow, 2017).

Rationalism, which regards reason as the prime source of knowledge (Markie, 2021), lost its credibility when Nazism emerged, because it can be viewed as irrationalism (Riley, 2013). There is no rational explanation for the Nazis' monstrous actions! Hence, Descartes' (2016/1644) conclusion that humans are rational, and Kant's (1998/1781) belief that there is a moral law within people (p.1), were/are very hard to accept. The rise of positivism was one consequence (Riley, 2013). From a group analytic perspective, socio-politico-economic power dynamics and unconscious processes started to corrode human rationality during the period of National Socialism in Europe (1933-1945) (see Volkan et al. (2002).

Inherent in positivism is the promise of a 'scientific' (better) future. Thus, I suggest that positivism gave hope, which could be another explanation for its upsurge. Hope is a wish for something, which is accompanied by a belief that this wish can be obtained. Furthermore, Nazism itself may have inadvertently resulted in the spreading of positivism across the globe. After Hitler became the German Chancellor in 1933, many Jewish intellectuals sought refuge abroad. When the Jewish Reichenbach moved to the USA to escape Nazism, he brought positivism to America, founding an intellectual circle in Los Angeles (Eberhard, 2021). Combining empiricism with modern mathematical logic to create a scientifically and technically informed philosophy, Reichenbach's inclusion of a probabilistic approach is considered a major part of the legacy of logical empiricism (Kitcher, 2025).

Additionally, the dissemination of positivistic postulates/ideas in prestigious philosophical journals and books contributed to positivism's influence (Creath, 2022). Moreover, positivistic ideas were mainly developed by

privileged White, middle-class, European (and later American) males, who were in a position of power. This would have contributed to positivism's rise, because power entails the imposition of a dominant worldview (Harvey, 2010) that structures relations unconsciously (Dalal, 2001).

1.8.2 Science as Replacement for the Problem of Death

Positivism and science are associated with modernity, which has implications for how death, theology, and the branches of philosophy were viewed. Positivism's emphasis on science contributed to its rise. Before the Enlightenment, beliefs about the immortality of the spirit/psyche protected individuals from fears about the transient nature of their existence (Vosmer, 2022). As a result of being 'enlightened', these metaphysical beliefs were discarded. Giddens (1990) notes that modernity is a way of life that is characterized by scientific advances. Thus, Nietzsche's (1884/2019) assertion that the essence of modernity was the 'death of God' (there was no good reason anymore to believe in the existence of God, Remhof, 2018) is poignant. It is reflected in positivism's emphasis on science, which may have served an important unconscious function for philosophers. Since God and metaphysics had been dismissed as mythical thinking, a 'replacement' was needed to deal with the 'problem of death'. I suggest that science is a substitute for metaphysics, fostering the illusion that science will fix death issues. This could explain why positivists wanted to equate philosophy with science and advanced the Philosophy of Science.

1.8.3 Ignoring Ontology: A Defensive Maneuver

Most people do not think about death as an inevitable part of Being (Heidegger, 1978) but experience death anxiety (Becker, 1973). Psychic defenses are unconsciously employed that enable people to manage their fear of death, and the existence of defense mechanisms has been evidenced (see Cramer, 2000). I suggest that defensive mechanisms were involved in positivists' neglect of ontology. This is not to say that defense mechanisms can be neatly separated. A defensive maneuver may include a mixture of defenses.

Historically, the formation and rise of logical positivism/empiricism (1918–1955) occurred in the aftermath of the First World War (1914–1918) and during the Second World War (1935–1945). Both the consequences of war and of the power structures of National Socialism must have brought death to the fore of positivists' minds. Positivists' *bloody reality* consisted of annihilation and involuntary migration of millions of people. This must have been difficult to endure. How is it possible to philosophize reality when surrounded by casualties? So, the emphasis on epistemology (sublimation) could be part of a defensive maneuver unconsciously employed to deal with the threat of annihilation. Forgetting about (repression) or psychologically detaching themselves (dissociation) from the gruesome realities would have been necessary in order to philosophize at all. Positivists' neglect of ontology could be viewed as disavowal, a defense that allowed them to believe that such reality was not happening to them. Unconsciously, reality and everything associated with it, including ontology, could have been relegated to the social unconscious, because reality was too painful and the philosophers could have been too traumatized to even question why they ignored ontology in their explication of positivism. But even if they had become aware of this neglect, it would have been denied, according to Hopper's (1996, 2001, 2003; Hopper & Weinberg, 2011, 2016, 2017) theory of the social

unconscious. People may reach the logical conclusion that certain assumptions and/or norms are erroneous. Nevertheless, they may subsequently deny those fallacies, or if they do not, they may *not* sufficiently problematize their conclusions (Hopper, 1996).

1.8.4 Positivism as Social Defense

Freud (1921), Hopper (2003), and Volkan (2004) showed that groups unconsciously influence individuals' emotions and behavior. If conceptualizing the positivist movement as a large group, positivism would have impacted others, including the public. In particular, Hopper's (1997, 2008; 2019) theory of the fourth basic assumption is relevant, because it explains how traumatic experiences can lead to incohesive societies (either by massification or aggregation). A shift from aggregation to massification could have occurred, resulting in masses of people identifying themselves with positivism. Whilst this could be viewed as a social defense (application of psychoanalytic defenses to social groups, see Lawlor, 2009), *positivism itself* might have served as a social defense against existential anxieties and trauma. Even the term 'positivism', chosen by Comte in 1822, has never been replaced. It encourages an association with positivity and could be regarded as a disavowal of negative emotions, enabling social/scientists to fully concentrate on socio-political developments and on technology to re-build societies and infrastructures. If positivism functioned as a social defense, this could explain why it became so pervasive in the social sciences (Riley, 2007) and in psychotherapy research.

1.8.5 Basic Assumptions as Explanation for the Split of Positivism

Bion's (1961) theory of basic assumptions is equally useful. Any group may be governed by primitive anxieties at times, Bion suggests, which impede its capacity to function rationally. Three basic assumptions are then unconsciously employed to defend against anxiety, and groups oscillate between them. In 'pairing' or 'dependency', groups unconsciously select a pair, or they search for a leader who will save/rescue the group. Alternatively, in the 'fight/flight' mode, group members engage in aggression or avoidance. Essentially, basic assumptions interfere with the individual's ability to reason, compelling her/him to think or behave according to the valency this person has. Valency refers to a person's *preparedness to act on basic assumptions*, i.e., defensive reactions against psychotic/survival anxiety. They originate within the individual as powerful emotions associated with a specific cluster of ideas. Not only do they 'compel' the individual to behave accordingly but also lead to this individual being attracted to others, who are imbued with the same feeling. Borrowing from chemistry, Bion termed these bonds 'valency' due to the instantaneous nature and strength of the attraction.

Initially, the majority of positivist acted on the 'dependency' basic assumption (seeing Comte as the role model, leader), I suggest, until the basic assumptions 'pairing' and 'fight/flight' became more dominant due to survival anxiety associated with World War I and its aftermath (rise of fascism, poverty). It would explain why logical positivism was formed by Schlick, Reichenbach and others. As fascism was spreading, there was disagreement ('fight') among positivist philosophers, and the movement became divided ('flight'). New circles (Vienna circle, logical positivism; Berlin circle, logical empiricism) were formed, separating positivists into logical positivists and logical empiricists. After World War II, financial hardship and migration led to new survival anxiety and most

had a valency for the basic assumption fight, I suggest. The logical/empiricist movement disintegrated and post-positivism emerged. Fundamentally, the fight-or-flight response serves self-preservation.

Moreover, I suggest that 'dependency' was the dominant basic assumption that was employed when neo-positivism/modern positivism upsurged. Bion's (1961, 1962a) conceptualization of valency is helpful to explain this further. People (philosophers, positivists, scientists, researchers, psychotherapists) with a valency for the basic assumption 'dependency' and/or 'pairing' would have overlooked neo-positivism's flaws.

Flaws include the inherent lack of suitability and theoretical validity of neo-positivism's empirical science model for psychotherapy research, i.e., it ignores the rich data of subjective experience, because its philosophical, statistical, and methodological framework cannot address it (e.g., Schnepf & Groeben, 2024). One might argue that this results in a methodology that is too narrow and inefficient, because it cannot study all aspects of humans. After all, the authority of methodological positivism is inextricably linked to the immense success of the natural sciences, where mechanisms operate regardless of human subjective experience. There is a reality that exists independently of humans, positivism assumes. Historically, it seemed plausible to imagine our social world in the form of universal laws due to specific macrostructural politico-economic conditions, e.g., Fordism or Keynesianism (Steinmetz, 2005). As Paley and Gartrell (2008) note, for Comte, there could have been a science of society with universal laws akin to those in the natural sciences. His label 'positivism' stood for a unity of science (all sciences can be integrated into one single system). Epistemologically, there could be no knowledge of any reality beyond sensory experience. Even though Comte acknowledged the impossibility of obtaining an *absolute* truth, nonetheless positivism is committed to establishing the absolute truth. Such naïve realism and psychotherapy research are *not* in harmony, because subjective experience itself is the subject matter of such research. Thus, positivists encounter several fundamental obstacles. In the natural sciences, unlike the humanities/social sciences (see e.g., Levitt et al., 2022), subjective experience is treated as 'noise' and excluded. Similarly, the researcher's own unconscious biases constitute noise, which is problematic. Ultimately, because subjective experience is unobservable and intangible, it is treated as a matter of opinion that lacks any objective reality (see Liu, 2022). The consequences of these ontological and epistemological fallacies (see Fourcade, 2007) are that human subjective experience is dismissed as the primary object of study due to ontological reasons. Secondly, the qualitative methods that are required to identify the data within the subjective realm are disregarded from an epistemological point of view.

Put simply, qualitative methods rest on a relativist *ontology* (reality is subjective, multiple realities exist) and on an interpretivist *epistemology* (knowledge is socially constructed).

1.8.6 Idealized Part-Object

I suggest that variants of positivism and quantitative methods function as idealized part-objects. Foulkes (1964) situated part-objects at the projective level of communication, which is characterized by splitting, projections, and projective identification (see Klein, 1988/1946). It involves seeing a person/thing (interpretivists,

psychoanalysts, religion, metaphysics) *only as bad/good* and then *projecting the unwanted parts* (flaws of positivism) into other people/things/groups (psychoanalysts, metaphysics, interpretivism, Indigenous people, philosophies), who then *become identified with these projections and are denigrated* (their views are inferior, because they reflect metaphysical thinking).

Splitting could explain why it took the logical positivist Hempel until the 1960s to acknowledge the flawed basis of logical positivism (Lutz, 2025), which other philosophers had already done (see Dewulf, 2022).

As for the 'bad object', psychoanalysis or Indigenous philosophies were dismissed as unscientific. Some psychoanalysts and philosophers from the Global South may have identified themselves with denigrating projections. So, they only view their theories/philosophies as inferior.

1.9. Explanations for Positivism's Resurgence & Dominance over Time

George Steinmetz (2005) analyzed the epistemological unconscious of the social sciences. Focusing on sociology and the USA, he suggested that positivism's influence in the mid-20th century could be due to the politico-economic climate of Keynesianism/Fordism in America. However, Fordism and Keynesianism peaked *after* World War II (1945) and lasted until the 1970s (see Jessop, 1992, for discussion). By the mid-1940s, positivism had already established itself as a respectable philosophy of science (see Uebel, 2024). Focused on the USA, Steinmetz' elucidation does not suffice for European countries, such as Britain, and it does not explain positivism's popularity in psychotherapy research (in the humanities). Alasuutari (2010) discusses aspects of neoliberalism, which seem to be linked to the increased demand for quantitative methods in the social sciences and to RCTs which became the gold standard in the USA in the 1970s.

Historically, methodological positivism seems to have declined from the 1950s to the 1970s, as qualitative methods started to become more prevalent. Alasuutari (2010) presents figures that show a decline of quantitative and an increase of qualitative publications in some countries for several decades. If one accepts this as evidence for the decline of methodological positivism in the humanities and social sciences, then its popularity decreased. However, qualitative methods incorporated quantitative coding (St. Pierre & Jackson, 2014) and operationalism. Thus, I find it problematic to conclude that quantitative methods really declined. Instead, they managed to masquerade under the name of 'qualitative' method, if we take post-qualitative scholars (e.g., St. Pierre & Jackson, 2014) criticism seriously.

Philosophical positivism died in the 1960s when Hempel announced that he no longer believed in logical positivism (see Alvesson & Sköldberg, 2009). It was a temporary death that lasted until the 1990s. Methodological positivism started to openly dominate again in the era of EBP, which became very popular in the 2000s (Murad et al., 2016). Ultimately, this means that philosophical positivism was resurrected, albeit in the weaker version of neo-positivism, because the quantitative paradigm needs a philosophical base, and this cannot be idealism or rationalism.

With regard to explanations for this resurgence and quantitative monopoly in psychotherapy research, a lack of critical thinking, neoliberalism, and an epistemological unconscious appear to be good candidates.

On their own, they seem insufficient as explanations.

Frie (2014) has argued that we cannot detach ourselves from culture. To think that psychotherapists, researchers, and ordinary people can distance themselves from their surrounding research culture is, therefore, illusory. Organizations, such as NICE, and researchers, who advocate for the wider adoption of EBP in mental health but also state that "the efficacy and effectiveness treatment research literature must be bolstered" (Cook et al., 2017, p. 543) mold a positivistic research culture. Clients'/patients' expectations to receive evidence-based psychotherapy (e.g., O'Callaghan et al., 2023), and them prioritizing "effective treatment" (Coulter et al., 2020, p. 189), endorse this type of research culture. Expectations of outcome, i.e., that therapy will be effective and lead to change of symptoms (see e.g., Dew & Bickman, 2005; Tambling, 2012), and clients' affective perceptions (e.g., Stefana et al., 2024) will strengthen a positivistic research culture.

Furthermore, apart from the obvious (only quantitative methods can demonstrate causality), I suggest that there must be unconscious reasons, since humans are not always aware of what they do or why they do something, as neuropsychoanalysis has shown. Thus far, I have pointed to defensive maneuvers, positivism functioning as a social defense and being an idealized part-object, and some people having a valency for positivism, as possible reasons for its rise. These unconscious processes could also be involved in positivism's resurgence. Admittedly, this is speculative and still somewhat limited. A broader explanation is needed. Methodological/philosophical positivism could be an ideology, i.e., a doctrine that shapes a set of attitudes (Sue et al., 2007), and people's ability to think critically could be hampered by unconscious processes.

1.9.1 Quantitative Monopoly: Methodological Positivism As Ideology

Ideologies can work through laws, policies, institutional practices, and interpersonal interactions. Take the quantitative paradigm, which aims to establish a strong relationship between knowledge and truth. Nobus and Quinn (2005) assert that it makes people believe that scientific knowledge is the best and should be shared with the public, policy-makers and others, who have a right to know which psychotherapy is evidence-based. They advocate questioning the universal cultural assumption that tells us that knowledge is good and shared knowledge even better. Dalal (2011) highlights that ideology legitimizes the interests of certain groups but in ways that are hard to recognize, because the purpose of ideology is to give the historical and contingent the appearance of the natural and inevitable. In a television discussion, Žižek argues that we no longer notice ideology, because it is everywhere (SRF, 2016).

How ideology works is brilliantly depicted in *They Live* (1988), directed by John Carpenter. The protagonist (Roddy Piper) finds a pair of special sunglasses that allow him to see the real message (ideology) behind adverts, propaganda, posters etc. So, he can see the world as it truly is. Normally, we imagine ideology as glasses that distort our vision of something. To see reality as it really is, we would have to take the glasses off, Žižek explains. In this film, ideology expresses normality. To see the truth, one must *put on* these glasses.

Applying Žižek's explanation to the positivism, we need such glasses to see the truth underneath its ideology ('obey scientific

dictates'), which is so engrained in the surrounding 'research culture' (Royal Society, 2025b), that people do even recognize it as ideology. Why? Ideology is unconscious, not only to the oppressed but also to the oppressors, with each genuinely believing that the status quo is an expression of the natural order of things (Althusser, 1969).

In any period, one particular worldview prevails and extensively dominates our mental faculties, leading to specific ways of experiencing events, Žižek (SRF, 2016) explains. During that time, nothing else seems to exist. Then suddenly the ideology becomes clear. I suggest that this happened with philosophical/methodological positivism. However, not every person wants to see the truth, some are quite happy not to see it, because truth is painful, Žižek insists. Such denial forms part of Hopper's (2001) theory of the 'social unconscious', which is another word for ideology. Socially unconscious processes ensure this denial. To change an ideology, you must first *beat ideology out of yourself*, Žižek (SRF, 2016) asserts, before you can address it in others.

1.9.2 How Thinking Critically about Positivism could be Affected – Bion's Theories

Critical thinking can be traced to Greek Presocratic methods of questioning (Lau, 2024). A lack of critical thinking has been proposed by Gelo et al. (2020) as one of the reasons for the quantitative monology. Interestingly, Bion (1959/2013, 1965, 1967) described how the mind may attack its own capacity to connect thoughts, feelings, and experiences. When the links between ideas/thoughts are broken, symbolization collapses, resulting in fragmented thinking. So, critical thinking becomes impossible, which is relevant to Gelo et al.'s (2020) argument. Furthermore, in his work on thinking, Bion (1962b) proposed that binary thinking is a sign of non-thinking and of acting out. Thus, the common binaries science/non-science would indicate non--thinking. Additionally, Bion (1962b, 1965, 1967, 1997) highlighted the pain of thinking, the defenses associated with it, and that the individual or a group can cling to pre-formed explanations rather than learning from experience (Bion, 1962a), especially due to defensive processes, such as basic assumptions (dependency, fight-flight, pairing) (Bion, 1961, 1962a). When looking at the current scientific monism through Bion's psychoanalytic lens, I surmise that some people may be unable to think critically about the quantitative monopoly in psychotherapy research, because positivism is historically associated with pain and trauma.

1.9.3 Employed as Social Defense during Economic Instability

Logical empiricism/positivism was formed during times of severe economic hardship and instability. If accepting that it was employed as a social defense against existential (financial) fears, I would expect that methodological positivism spreads during economic crises and declines during times of economic stability. When looking at historical events, this pattern is noticeable.

By the 1960s, many philosophers (see Alvesson & Skőldberg, 2009) and researchers were opposed to logical positivism and the quantitative paradigm (see Seale et al., 2004; Seale, 2018). It was a time when Western societies started to flourish economically. Peace became a preoccupation. So, positivism was no longer needed as defense against annihilation anxiety. Psychologically speaking, as repression loosens, people no longer view the world as part-objects, where splitting, projections, and projective

identification prevail. So, they can assess events, theories, and philosophies more rationally. Philosophers and researchers would become acutely aware of the shortcomings of methodological positivism and reject it, leading to its decline. From the 1970s onward, the qualitative paradigm started to become more popular in the social sciences (see Alasuutari, 2010).

In the 1980s, a resurgence of methodological positivism occurred in the social sciences (Steinmetz, 2005). The world economy was suffering, and 1982 was a dismal year for many economies. Unemployment and inflation were high, and world trade was collapsing (Green, 1983). Sadly, faltering economies also resulted in European and American recessions during 2000–2001 (Kliesen, 2003), the global financial crisis from 2007 to 2008 (PositiveMoney, 2024), and high European inflation rates from 1997 to 2023, peaking in 2022 (Galan, 2026). Over the past two decades, we have also witnessed terrorist attacks, wars in the Middle East, Ukraine, and elsewhere, resulting in involuntary mass immigration to Europe, which has placed an economic burden on many countries.

Gradually, since the 1980s, methodological positivism has become more influential again in psychotherapy research, when mixed methods (combination of quantitative and qualitative) started to become more widely used (see Alasuutari, 2010). Over the past three decades, quantitative methods have been favored, leading to a quantitative monopoly in psychotherapy research (see Gelo et al., 2020). I suggest that methodological positivism could have functioned as a social defense against existential fears during times of economic instability. This would explain the historical fluctuations of positivism's methodological dominance, its decline, and contemporary dominance in psychotherapy research.

1.10. Why is the Positive Ideal of Methodological Positivism Needed?

Žižek (1996) points out that the relation between science and psychoanalysis is often reduced to the question whether psychoanalysis is a science. Critiques or assessments of psychoanalysis tend to be elaborations on this question. However, the more interesting question is why a positive ideal of science is needed. Similarly, I would ask why the positive ideal of methodological positivism is needed.

In my elucidations thus far, I have suggested an interplay of various defensive maneuvers. Positivism may serve as protection against death anxiety and existential fears, or function as an ideology or idealized part-object. Critical thinking is hampered. Many people may need the positive ideal of methodological positivism, I suggest, because it allows them to cope with their own mortality.

2. Critical Discussion of the Monopoly of the Positivist Epistemology

In this Section, I will discuss whether positivism might be implicated in philosophical racism and epistemic oppression, additionally illuminating possible consequences of the dominance of the positivist epistemology in psychotherapy (research). According to Cudd (2006), the concept of oppression developed alongside equity and justice. It always involves harm, because it affects a social group's membership and the stigma or privilege associated with it. Historically rooted, oppression is always systemic and socially structured. Central to oppression

are power and power relations (Harvey, 2010), in which the imposition of dominant worldviews renders the lives of marginalized people invisible or inferior (Young, 1990).

2.1. The Overcoming of Metaphysics & Neglect of Religion in Psychotherapy (Research)

The scientific overcoming of metaphysics by the positivists (Horkheimer, 2004) deprived metaphysics of its own legitimacy (Gadamer, 1979). Whether the reason for doing so is linked to secularization or imperialism/colonialism, and its insistence that Indigenous societies needed to be civilized both by the enlightened, superior, White Western Europeans (Boisen, 2013) and by science (Harrison, 2005), is an interesting question.

Simply put, colonialism and imperialism are practices of domination (Horvath, 1972). Colonialism is linked to secularization, which arose in the 1850s (Wilson, 2017), two decades after Comte's (1988/1853) *Introduction to Positive Philosophy*. Like positivism, secularization makes normative assumptions about the value of the secular. Both the supernatural and religion are belittled (Asad, 2002; Mahmood, 2016).

For Sigmund Freud's psychoanalysis, religion was equally irrelevant. Aiming to establish psychology as a science, Freud regarded religion as a means that prevented people from confronting reality (Lin et al., 2026). Religion was the stronghold of irrationality, which emanated from the child's helplessness and wish for protection (Shafranske, 2009).

Discussing whether it was secularization, positivism, or Freud's emphasis on science, which led to the neglect of religion and spirituality in many psychotherapies, is beyond the scope of this article. Suffice it to say that religion and spirituality, despite their importance to clients (e.g., Bouwhuis-Van Keulen et al., 2024), are neither a primary focus of psychotherapies (e.g., Shafranske, 2009; Marmarosh, 2024), nor of training programs (e.g., Hage et al., 2006; Pearce et al., 2020; Wong, 2020), nor of psychotherapy research (e.g., Post & Wade, 2009; Lin et al., 2026). Disconcertingly, Abrams (2023) suggests that most American psychologists have little training on how to address spirituality and religion in psychotherapy.

2.2. Philosophical Racism

It could be argued that the quantitative methods may inadvertently perpetuate racism, because these methods rest on philosophies of the Global North, some of which have been described as racist. For the founder of positivism, Comte (1988/1853), metaphysics was just a stage between theological and positivist thinking. Comte dismissed theology and metaphysics as superstition, mystical, and primitive. Only positivism gave way to science (see Mautner, 1997). Amongst others, African (e.g., Marais, 1984) and European (e.g., Horkheimer, 2004) philosophers have criticized positivism's anti-metaphysical stance. It led to an 'eclipse' of ontology (Horkheimer, 2004) and even an "epistemicide" (Maris, 2020, p. 309), because African episteme with its focus on lived communal experience and spirituality has become an impossibility. Nwosimiri (2024) describes how African knowledge was degraded due to the imposition of Western knowledge, a hegemonic influence that persists. In addition to the epistemic oppression of African knowledges (e.g., Maris, 2020), cultures in the Global North (e.g., Britain), and some of their philosophies, have been accused of epistemological racism (e.g., Bernasconi et al., 2013).

According to Marks (2017), science tolerates racism, i.e., a belief in the inequality of races. Marks defines 'scientific racism' as the use of science to justify this belief (p. 126). Furthermore, Ramose (1999) argues that Western philosophy has played a decisive role in colonial oppression. The view that philosophical and liberal political theories are racist (Veraart, 2017), is shared by several philosophers (e.g., Bernasconi, 2021). Aristotle, an archetypal empiricist (North, 2005), has been called a pioneering racist thinker of the Western tradition by Mill (2021). For Aristotle, non-Greeks (barbarians) and women were regarded as primitive, irrational, and inferior human beings (Maris, 2020).

In sum, if accepting that science is associated with colonialism (Seth, 2009), and that positivism is directly linked to colonialism (e.g., Anghie, 2005), and that racism and science go together (see Mncube, 2017), then positivism is racist and, by implication, so are the methods that rest on this philosophy.

2.3. Coloniality, Epistemic Violence & Oppression

As such, culture is not static but can change over time (Fried, 2014), which points to the close connection between culture and history. Thus, one needs to examine both cultural and historical assumptions, beliefs, events, and so forth. While my argument leans more toward British empiricism (e.g., Locke), my use of the concept of coloniality is not so much in reference to the colonial history but relates to epistemological imperialism, and the imposition of Northern knowledge as a hegemonic standard for others (Bou Zeineddine et al., 2022). Coloniality can be described as a historically rooted domination of modern systems of knowledge production (the ways of being attuned to them) over disempowered communities. As a former colonizer (see Kohn & Reddy, 2023), contemporary Britain has not freed itself from the traces of colonialism, i.e., a *way of thinking* about oneself and others in terms of domination and submission (Strakosch, 2015). Ibtisam (2017) suggests that the British Empire has never really died but just morphed into a new form. As Dalal (2001) highlights, history and colonial power structures continue to influence social systems and people unconsciously. Therefore, one should not assume that current systems, such as NICE in Britain, have nothing to do with colonialism, just because they were established in the 21st century. The mechanisms through which power and privilege work are most certainly complex. They can include epistemic and methodological values, as well as prejudices against certain types of knowledge.

Similar to findings from the social sciences (e.g., Gingras & Mosbah-Natanson, 2010; Mosbah-Natanson & Gingras, 2014; Bou Zeineddine et al., 2022), Solomonov et al. (2025) have found a quantitative domination in the produced psychotherapy research from Europe and North America. Sadly, the systems of scientific knowledge production are inequitable (Gingras & Mosbah-Natanson, 2010). Bou Zeineddine et al. (2022) problematize that these systems are based on power structures that favor historically dominant groups. Even though the authors are describing the conundrum in social psychology, these issues seem equally relevant to the field of psychotherapy (research): coloniality shapes what researchers see as important in the contents of their profession.

Despite claims that Comte's hierarchical socio-evolutionary scheme has been repudiated, Shipley and Williams (2019) assert that the underlying bias is still alive. Implicitly, Comte's hierarchical categories

of "modern" and "primitive" have been replaced by "metaphysically exclusive" and "metaphysically inclusive". People's progress from darkness to enlightenment is measured in the degree of their acceptance of the Western scientific worldview, Shipley and Williams (2019) suggest.

Carnap's (1958) insistence that the metaphysical and theological unscientific ways of thinking had enslaved people, is an example of how some logical positivists argued. I would interpret the juxtaposition of metahysics and enslavement as a disavowal of slavery and colonialism. By repudiating the connection of Comte's positivism to colonialism, a historical truth could be repressed. It seems to me that logical positivists were equally 'enslaved' by science, which became an idealized part-object. I view the insistence on derogatory claims about metaphysics as a defensive splitting in the servitude of science, unconsciously leading to a recreation of prejudice, oppression, and unequal power dynamics through positivism.

As Bou Zeineddine et al. (2022) discuss, mechanistic positivistic epistemology and methods, experimental designs, and measures are privileged at the expense of openness to pluralism. Similarly, our psychotherapy discipline may perpetuate the sociopolitical assumptions, preferences and agendas of those that are most powerful and privileged.

Since treatment/outcome research (meta-analyses, systematic reviews, RCTs) is prioritized, the use of outcome measures has become increasingly important in psychotherapy (McAleavey et al., 2024), despite inconclusive evidence regarding their usefulness (e.g., Kendrick et al., 2016; de Jong et al., 2021). To be clear, I am not against outcome research (e.g., Smith et al., 2024; Rosendahl et al., 2021).

However, for scholars outside the Anglophone and the Western, Educated, Industrialized, Rich, and Democratic world, aka WEIRD, (Heinrich et al., 2010), an outcome-focused approach can be inappropriate (Bou Zeineddine et al., 2022). Nonetheless, in South Africa, treatment guidelines tend to draw on NICE and the American Psychiatric Association, Kadish and Smith (2020) explain. They suggest that the acceptance of psychoanalytic interventions in the public sector will depend on clinicians' capacity to convince governmental decision makers of the *long-term efficacy* [my emphasis] and relevance of a psychoanalytic paradigm to the South African context (p. 171).

This shows that the positivist paradigm has spread to the Global South, where it dictates what kind of research should be conducted: efficacy studies.

However, "knowledge it not what it seems" (Nobus & Quinn, 2005, p. 2) and psychoanalysis can place forms of knowledge in a dialectical relationship with non-knowledge. In so doing, it reveals people's blindness and ignorance. Nobus and Quinn view the quantitative paradigm culturally as a "knowledge provider and winner" (p. 3). Its epistemic capital has been growing through psychotherapists' continuous visits to the "institutional banks of knowledge" (p. 3), to use Nobus' and Quinn's metaphors. These banks are the websites, documentations, and publications of quantitative success: the empirically validated psychotherapies. Where there are winners, there must be losers. Indigenous and qualitative paradigms, and psychoanalytic therapy traditions are but a few 'knowledge losers', because their epistemic capital is decreasing due to the investments in (funding of) quantitative research (treatment studies). Bou Zeineddine et al. (2022) note that coloniality can be observed indirectly. Indeed.

To demonstrate the efficacy of psychoanalytic therapy, RCTs must be carried out. Notwithstanding that even effectiveness studies are exceptionally difficult to conduct, according to Swartz (2006), because the real-world situation is complex and chaotic in South Africa, additionally, efficacy studies are expensive (see Speich et al., 2018). I would agree with Adams et al. (2015) that the universal imposition of certain standards (positivistic), across contexts, is a form of epistemic violence that systems, such as NICE and APA, perpetrate. Epistemic violence in the mental health profession can be observed in the form of marginalization of scholars in the Global South and in the disparate access to psychotherapy there (e.g., lack of infrastructure/trained psychotherapists, see Patel et al., 2025; Beresford & Rose, 2023). Proponents of Western or Indigenous worldviews may experience a visceral and often hyperbolic defensiveness, in the former this will happen when science is criticized, Williams and Shipley (2023) claim.

Linked to this is epistemic oppression. Sue et al. (2007) note that oppression operates through ideologies, laws, policies, institutional practices, or interpersonal interactions. By insisting on the discoverability of one objective truth through quantitative, empirical methods and by accepting only scientific knowledge, positivism has played no small role in the epistemic oppression of experiential, affective, tacit, and relational knowledge. Under the rule of the scientist's omnipotent knowledge ego (Nobus & Quinn, 2005), Indigenous, relational and psychoanalytic knowledges are rendered inferior. Research must be value-free due to the ego's strive for objectivity and belief that the researchers' values can be put aside (Pretorious, 2024). Scientific inquiry can achieve neutrality through rigorous methods that exclude subjective influences, positivism holds (Chilisa, 2020). Hence, axiology is irrelevant, because science deals solely with facts, and traditions that emphasize axiology (e.g., African, Indigenous, see Bayuo, 2025) are pushed aside. Axiology is the study of moral values, beauty, and taste (Hasan, 2016).

2.4. Consequences for Psychotherapy

By equating positivism with science (Lande, 1996), RCTs have become the methodological 'gold standard' (Hofmann et al., 2025), and quantitative methods are prioritized in psychotherapy research. This prioritization extends to funding. For example, an estimated four percent of the National Institute of Mental Health's (NIMH) budget in 2020 was spent on psychotherapy *treatment studies*, and CBT receiving the largest portion of money of the psychotherapies (Galves et al., 2025, p. 117). The NIMH does not invest in research of psychodynamic therapies, laments the Psychotherapy Action Network (2026) in Italy. Indeed. CBT seems to be the therapy with the most power.

2.5. Where Do Psychotherapies & Research Go from Here?

As it stands, only positivistic methods can demonstrate causality, and causality is important to people. Starting in childhood, where young children continuously ask 'why?' (Chaudhary, 2020), adults remain curious about causality (why), but also make erroneous judgements about causes (Cengel, 2022). So, people may readily and easily develop mental causal models about phenomena, events, and the connection between things (Sloman & Sloman, 2009). Ironically, our human desire to 'know why' might turn out to be the biggest stumbling block when it comes to shifting the focus away from efficacy (causality) and effectiveness research.

Whilst I agree that transtheoretical principles (Westen et al., 2004), such as clients' expectations of therapy, motivation and problem awareness, the therapeutic alliance, facilitating corrective experiences, and reality testing (Rohfing et al., 2025) should be studied, I do not believe that they will become a priority. Call me a pessimistic, but I do not think that non-positivistic methods will ever acquire the same status as positivistic methods for the reasons discussed so far. There could be a further reason.

Undoubtedly, the relationship between applied research, clinical practice, and theory has been fundamental to systematizing psychoanalytic knowledge (Fonagy, 2003). However, *researchers* (e.g., Keane et al., 2017; Smith, 1999; Zavala, 2013) and *psychotherapists* (e.g., Khanna, 2003; Nayak, 2021, 2025; Nayak & Forrest, 2024; Swartz, 2023) have also recognized the need for decolonization. It involves identifying colonial systems, structures, and power relationships, reflecting on why certain knowledge prevails, and adjusting cultural perceptions and power relations to achieve a cultural shift (University of Essex, 2025). So, decolonizing research requires shifting the culture of exclusion and denial to one that makes space for other philosophies and knowledge systems. Unfortunately, there are many barriers. For example, the social structures woven into the fabric of academia. Aligning themselves with institutional interests, many academic researchers focus on securing grants and publishing to advance their careers (Hafez et al., 2025). This requires the use of quantitative methods. Additionally, the colonial cycles of empirical knowledge production and knowledge 'hoarding' hampers the knowledge transfer to communities most impacted by a research project. Sharma and Kivell (2024) have proposed other ways of knowing that challenge the colonial practice of psychotherapy by moving away from Western-centric theories. On paper, it sounds easy. But what would be left of Freud's psychoanalysis if his undoubtedly Western-centric theories were discarded? Are most psychoanalysts really prepared to give up the Oedipus Complex? What would replace it as one of the cornerstones of psychoanalysis?

Recognizing White privilege, addressing epistemological power differentials, and thwarting the re-creation of the oppression of knowledges could contribute to the decolonization of psychotherapy and research, according to Sharma and Kivell (2024). I agree with the authors. However, power *unconsciously* structures interactions within and between social systems and their members (Dalal, 2001). So, the unconscious must be made conscious first. Becoming aware of one's own defenses in practice/research and educating others on unconscious processes might be essential steps to address power imbalances in psychotherapy research.

Summary & Conclusion

I have described and discussed the different meanings and versions of positivism by focusing on psychotherapy research and psychotherapies, especially psychoanalysis. In the light of the many criticisms, the methodological dominance of positivistic methods in psychotherapy research might be difficult to accept, but it cannot be dismissed. Thus, I have provided possible explanations for the rise and dominance of philosophical and methodological positivism. An interplay of various defensive maneuvers are possible reasons. Positivism may serve as protection against death anxiety, existential fears, and as an idealized part-object. À la Bion, a critical assessment of positivism might be hampered by unconscious processes that

interfere with thinking. Many people may need the positive ideal of methodological positivism, because it allows them to cope with their own mortality. As an ideology, positivism is powerful. Furthermore, my critical discussion of the consequences of positivistic dominance pointed to the epistemic oppression of both non-Western (Global South) and non-positivistic knowledge. Preferred providers of knowledge are positivistic methods. This has made CBT a winner and psychoanalysis a loser in the production machinery of empirically validated psychotherapies and evidence-based knowledge. Religious and spirituality struggle to make their way into many psychotherapies, possibly due to the neglect of axiology, the dismissal of metaphysics and the emphasis on epistemology in psychotherapy research. However, positivistic methods have their strengths, one being that they enable researchers to demonstrate the efficacy/effectiveness of psychotherapy. This seems to satisfy people's needs for causal explanations. Unfortunately, although some psychoanalysts have highlighted that knowledge is not what it seems, quantitative research is also a socio-cultural practice that is deeply embedded in many cultures. Not all functions of methodological positivism will be apparent due to socially unconscious forces, such as ideology, and power dynamics. Thus, epistemic oppression may not be immediately noticeable and the need for the decolonizing of research might be quickly forgotten. Sadly, positivism's methodological dominance leaves no space for other philosophies and knowledge systems. When the evidence-production is mainly confined to RCTs, the exploration of clients' subjective experiences becomes secondary. In this way, psychoanalytic methodologies/knowledge and the voices of clients, who are already underrepresented in psychotherapy research, would be silenced. Therefore, it is important that researchers and psychotherapists use their authority to influence the prevailing research culture by making people aware of the unconscious processes that are implicated in favoring one method over another. Psychodynamic therapists and group analysts are ideal candidates to do so.

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The Vertical Model of Therapist Stabilization (L1–L8) Under Chronic Stress

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Abstract Psychotherapists increasingly practice under conditions of chronic overload. In many regions, clinicians work while being continuously exposed to collective stressors such as war, forced migration, and long-term systemic instability.

Although the regulatory processes of patients have been extensively described in affective, relational, cognitive, and narrative terms, far less attention has been given to the therapist's own regulatory architecture: the conditions that allow the clinician to remain present, stable, and internally organized within the therapeutic encounter.

This article proposes a layered, vertical model of therapist stabilization (L1–L8) developed in the context of prolonged exposure to collective trauma. The model integrates contemporary affective neurobiology, phenomenological accounts of lived experience, and principles derived from Positive and Transcultural Psychotherapy (PPT after Peseschkian, since 1977). Stabilization is conceptualized as a dynamic organization across vertically related processes: somatic and sensory regulation, affective differentiation, relational attunement, narrative and cognitive coherence, cultural and transgenerational grounding, and existential orientation.

Clinical illustrations are drawn from an international stabilization setting for therapists working under conditions of war. The paper is conceptual and clinically grounded. Its aim is to offer a framework for understanding therapist stability under chronic threat and to outline implications for psychotherapy

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process research, supervision, training, and the ethical responsibilities of mental health systems.

Keywords: therapist regulation; trauma exposure; layered stabilization; chronic stress; psychotherapy process

Introduction

Contemporary psychotherapeutic practice is increasingly taking place under conditions of chronic strain. In many parts of the world, clinicians work while being continuously exposed to trauma: collective, prolonged, and woven into everyday life. War, forced migration, systemic instability, and the steady weight of emotional overload form the background in which many therapists now try to remain present, responsive, and clinically available (Dobiała, 2025). In these settings, regulation is no longer something that concerns only the patient. It becomes a question of whether the therapist can stay organized enough, moment to moment, to hold the therapeutic field.

Despite the extensive literature on affect regulation, burnout, and secondary exposure, we still lack an integrated theoretical model that describes how therapists stabilize themselves in real time, especially when they work under long-term, high-intensity conditions. Most existing approaches conceptualize therapist regulation in horizontal terms. They highlight individual techniques: mindfulness routines, self-care practices, stress-management strategies. These have value, yet they often remain fragmented and only loosely rooted in neurobiology. They rarely address the contexts in which therapists are confronted with persistent danger, uncertainty, or moral injury.

Positive and Transcultural Psychotherapy (Peseschkian, 1987) offers a holistic framework for understanding human functioning. It brings together the domains of the body, relationships, achievement, and spirituality/creativity. This framework provides a culturally sensitive, integrative view of mental health. At the same time, PPT was developed before affective neuroscience, predictive processing models, or modern trauma theory had shaped our understanding of regulation. The approach therefore lacks a neurobiologically grounded description of how therapists regain stability when these domains become destabilized under chronic stress.

Current findings in neuroscience emphasize that regulation is layered and hierarchical. It involves continuous interaction among autonomic physiology, sensory and interoceptive processing, affective systems, relational coregulation, narrative meaning-making, behavioral organization, and cultural or existential orientation (Smith et al., 2017; Porges, 2025; Barrett & Simmons, 2015). Under conditions of war and prolonged threat, these layers are often disrupted in sequence, creating cascading effects: loss of therapeutic presence, weakened relational attunement, and decline in clinical effectiveness. Yet contemporary psychotherapy models rarely offer a structured description of how these layers relate

to one another within the therapist's own regulatory system.

In response to this gap, the present article proposes a Vertical Model of Therapist Stabilization (L1–L8), developed in the context of supporting clinicians working in active war zones. The model describes a vertical orientation of regulation, differentiating among bottom-up processes (somatic, sensory, affective), middle-layer functional processes (relational, cognitive, behavioral), and top-down processes (cultural identity, existential meaning). Stabilization here is not a collection of techniques but a reorganization of the entire system across interconnected layers.

The model is further informed by clinical experience from the European Room for Listening (ERL; Dobiała, 2026), an international stabilization field created in response to the war in Ukraine. ERL offers an environment in which therapists working under chronic threat engage in relational coregulation without hierarchical intervention. In this article, ERL serves as an illustrative field for understanding how vertical stabilization supports clinical availability in extreme conditions.

The aim of this article is threefold: (1) to present a layered model of therapist stabilization, consistent with the areas of the balance model described by the concept of Positive Psychotherapy; (2) to integrate this model with contemporary neurobiological perspectives and trauma-informed approaches; and (3) to discuss its clinical, educational, and supervisory implications, with particular emphasis on high-stress and crisis contexts. By defining stabilization as a vertical, embodied, and relational process, the article offers a framework for thinking more precisely about therapist regulation under chronic threat.

Theoretical Background

Positive Psychotherapy: The Balance Model

Positive and Transcultural Psychotherapy (PPT; Peseschkian, 1977) understands human functioning through the dynamic balance of four areas: (1) body, (2) contact, (3) achievement, and (4) spirituality/creativity. From the outset, this approach has been holistic and transcultural, assuming that mental health does not result from the elimination of symptoms, but from a flexible balance between these areas.

Each of the above areas contributes separate regulatory and adaptive resources. The body provides the physiological and energetic basis for functioning; contact organizes relationships and co-regulation processes; achievement relates to action, agency, and the organization of life; spirituality and creativity enable the integration of experience into a broader horizon of meanings. Imbalances between these domains lead to symptoms, conflicts, and difficulties in functioning, which in PPT are understood not as deficits but as signals of overload or imbalance in the system.

Neurobiology of Regulation and Overload

Contemporary neurobiological models agree on one point: regulation is layered and hierarchical. It relies on the interplay between physiological, sensory, affective, relational, cognitive, and existential processes (Smith et al., 2017). At the most basic level, the autonomic nervous system (ANS) organizes the body's responses to perceived safety or threat. It forms the biological foundation of somatic regulation. Its functioning is tightly linked with the somatic layer (L1) and shaped

by sensory and interoceptive processing (L2), which determine how much stimulation a person can tolerate and how they orient to the environment.

Research on interoception and predictive processing suggests that emotions and arousal are shaped through ongoing predictive regulation of internal states (Seth, 2013; Barrett & Simmons, 2015; Khalsa et al., 2018). In this sense, affect emerges from the integration of bodily, sensory, and contextual signals. This helps clarify the distinction between L1, L2, and L3. The affective layer (L3) is biologically grounded, and its dynamics cannot be fully regulated by behavior or cognition alone. A key component of regulation is relational co-regulation. Developmental and neurobiological research shows that affective stability is deeply interpersonal. It depends on synchrony, responsiveness, and the neuroception of safety (Tronick & Beeghly, 2011; Schore, 2012; Porges, 2007). These processes form the core of the relational layer (L4), where the presence of another person has a regulatory effect regardless of the words exchanged.

Affective neuroscience adds another dimension. It describes primary emotional systems such as CARE, PANIC/GRIEF and SEEKING, which shape behavior and connection at a level preceding narration (Panksepp, 2010). Their activation organizes the dynamics of L3 and becomes especially important when considering overload in therapeutic work.

Under chronic stress, sensory overload, intense relational work, and trauma exposure, disruptions may accumulate across layers, affecting autonomic stability, the window of tolerance, predictive regulation, relational co-regulation, and access to higher levels of functioning such as narrative, action, and meaning. From this perspective, therapist stabilization needs to include all these levels rather than rely only on relaxation or cognitive strategies (Teicher & Samson, 2016; Ochsner et al., 2012; Schore, 2012).

Therapist Stabilization: a Gap in the Literature

Contemporary psychotherapy offers elaborate models of patient regulation, yet the therapist's own regulation remains surprisingly underdeveloped. Existing frameworks are often fragmentary, strongly tied to one theoretical orientation, and frequently reduced to mindfulness practices or general self-care advice, useful but only partially connected to the neurobiology of regulation. And most importantly: they rarely account for the kinds of contexts in which therapists may be working under extreme conditions, including war, chronic trauma, or prolonged systemic instability.

Positive and Transcultural Psychotherapy provides a solid systemic and cultural frame. Still, it requires a finer neurobiological articulation to describe:

- how a therapist stabilizes through the body, relationship, action, and spirituality;
- how different layers become active during clinical work;
- how sensorimotor overload alters access to narrative and meaning; and
- how to create stable, culturally attuned strategies and rituals of regulation.

In this sense, the vertical, layered model L1–L8 responds directly to a clinical need. It proposes an integrated, neurobiologically

grounded model of therapist stabilization, aligned with the four domains of PPT and applicable both in everyday clinical load and in extreme contexts, including war settings.

The Vertical Layered Model L1–L8

The vertical model describes eight layers of psychological organization (see Table 1).

Each layer represents a distinct mode of regulation, experience, and orientation. They stand in a dynamic, hierarchical relation to one another.

Each layer:

- has its own biological grounding;
- corresponds to one domain of the PPT balance model;
- fulfills a specific clinical function in the therapist's regulatory process;
- generates its own way of "knowing" and orienting within experience;
- and becomes overloaded in characteristic ways under chronic stress and intense clinical work.

Taken together, the eight layers form a coherent, dynamic architecture of therapist self-regulation. They make it possible to sustain presence, functioning, and the capacity for coregulation under high load.

Layer 1 (L1): Somatic (Autonomic) Regulation

L1 encompasses the fundamental physiological processes shaped by the autonomic nervous system: muscle tone, respiratory rhythms, sympathetic and parasympathetic activation, and general homeostasis. It provides the physiological basis for all higher layers (Porges, 2011). Dysregulation at this level appears as chronic hyperarousal, sleep disturbance, exhaustion, or shutdown responses. In war or crisis contexts, L1 is often overloaded long before emotional difficulties become consciously noticeable. This pattern is well-documented both clinically and in research on chronic stress and continuous trauma (McEwen, 2007).

Layer 2 (L2): Sensory and Neuroceptive Regulation

L2 refers to sensory processing and the non-conscious detection of safety and threat (neuroception). It includes sensory thresholds, integration of stimuli, and spatial-environmental orientation (Porges, 2011). Under prolonged threat, therapists may operate in a state of persistent neuroception of danger. This can manifest as sensory hyperreactivity or, conversely, a perceptual numbness. Dysregulation here narrows clinical presence even when cognitive control remains intact.

Layer 3 (L3): Affective Regulation

L3 includes the processes involved in feeling, modulating, and differentiating affect. This layer forms a bridge between somatic regulation and relational engagement, and it is central for clinical empathy (Schore, 2012). When L3 becomes overloaded, the system may narrow emotional range, tighten emotional control, or, conversely, become overly permeable. In war-related trauma work, a functional "flattening" of affect is often observed, a way to keep working, but at the cost of longer-term integration.

Layer 4 (L4): Relational Regulation

L4 concerns the capacity for coregulation, safe relational presence, and maintaining interpersonal boundaries. It includes attunement patterns, responsiveness, and relational safety (Tronick, 2007; Beebe & Lachmann, 2014). In war contexts, this layer is frequently strained. Therapists share the broader circumstances of their patients, absorb the weight of witnessing, and often have limited access to stable, professionally nourishing relationships. Dysregulation at this level leads either to relational withdrawal or empathic overload and both directly weaken the therapeutic process.

Layer 5 (L5): Cognitive-Narrative--Predictive Regulation

L5 refers to the capacity to symbolize experience, construct narrative, and generate predictive cognitive frames that organize perception and guide action. It integrates affective and relational information into coherent cognitive structures (Bruner, 1990), yet remains a representational rather than meaning-generative layer.

Under chronic stress, therapists may maintain high narrative competence and intact explanatory frameworks, while losing access to the somatic (L1–L2) and affective (L3–L4) strata beneath. As a result, narratives become increasingly survival-oriented, cognitively intact on the surface but progressively disconnected from vertical integration.

Layer 6 (L6): Functional and Executive Regulation

L6 refers to the capacity for planning, decision-making, and organizing clinical work. This is the layer most visible when assessing a therapist's "functioning." Preserved functioning at L6 can mask severe dysregulation in lower layers, creating an impression of stability that is not fully real. This pattern is well known in research on burnout and functional overadaptation (Maslach & Leiter, 2016).

Layer 7 (L7): Cultural and Transgenerational Regulation

L7 places individual experience within cultural, historical, and transgenerational contexts. It allows personal suffering to connect with collective narratives and activates transgenerational resources of resilience (Fuchs, 2018). This layer orients the therapist within a wider field, not only "my story," but the stories carried by communities and generations.

Layer 8 (L8): Existential–Spiritual Regulation

L8 refers to the capacity to orient oneself toward meaning, purpose, and the transcendent dimensions of experience. At this level, personal life events are situated within broader existential frameworks: the sense of direction, coherence, and connection with something larger than the individual, whether understood spiritually, symbolically, or relationally.

This layer integrates existential questioning ("Why do I live?" "What is my path?") with the felt experience of orientation toward the future. It is the highest-order organizing principle in the vertical system, shaping how all lower layers are interpreted and held. Dysregulation at L8 manifests as a collapse of meaning, existential fatigue, or a loss of inner orientation, even when functional and cognitive layers remain superficially intact. When L8 destabilizes, the entire vertical architecture becomes vulnerable, despite preserved external performance.

Vertical Stabilization as a Dynamic Process

The L1–L8 model treats stabilization as something that unfolds over time. Dysregulation usually appears as a cascade, not as an isolated failure of one layer. Effective stabilization, therefore, is not about "fixing" a single level but about restoring communication between layers. This perspective aligns with the process-oriented paradigm in psychotherapy research (Stiles, 2007).

Vertical Orientation of Therapist Stabilization

The Vertical Stabilization Model (VSM) describes how therapists maintain regulation through a dynamic, continuous flow across layers L1–L8 (see Table 2). Stability is not the result of applying a particular technique. It emerges from how the therapist's system is organized along the vertical axis. Such organization supports attuned coregulation, resilience against affective overload, and the ability to sustain a therapeutic field even under extreme conditions: war, chronic trauma, systemic disruption.

Unlike models focused on isolated interventions, VSM frames stabilization as an ongoing process happening simultaneously across biological, relational, cognitive, and existential domains. Regulation becomes the therapist's ability to keep a coherent vertical line of functioning, especially when the environment becomes unstable or threatening.

The Logic of "Bottom–Up" and "Top–Down" Stabilization

Vertical stabilization rests on two complementary regulatory directions: a bottom–up path and a top–down path. This dual organization is consistent with hierarchical models of the nervous system and with contemporary frameworks of affective and predictive regulation (Rao & Ballard, 1999; Friston, 2010; Seth & Friston, 2016).

Bottom–Up Stabilization

Bottom–up processes include layers L1–L3, the body and affect, the primary foundation of any therapeutic regulation. This includes somatic regulation (L1), sensory–interoceptive processing (L2), and affective modulation (L3). Its central task is to restore enough physiological stability to make relationship, reflection, and clinical presence possible. Research on trauma and regulation suggests that without relative balance in these layers, the system loses much of its capacity to integrate experience. Window of tolerance narrows, predictive processes destabilize, affect disorganizes, and relational contact weakens (van der Kolk et al., 2005; Schore, 2001; Khalsa et al., 2018).

Clinically, this means: a therapist operating primarily from cognition, without somatic or affective access, is particularly vulnerable to overload. This becomes even more pronounced in contexts of war, chronic danger, and continuous traumatic exposure. Bottom–up stabilization is therefore a necessary condition for therapeutic work, but not a sufficient one.

Top–Down Stabilization

Top–down processes involve layers L7–L8: culture, identity, values, existential meaning. They include cultural-generational orientation (L7) and existential/spiritual grounding (L8). Their function is to maintain a sense of direction, a vector of meaning that protects the therapist's system from fragmentation and burnout during prolonged stress. Research on therapist resilience

shows that meaning, values, and cultural anchoring offer strong protection against moral injury and existential collapse (Litz et al., 2009; Park, 2010). In contexts of war or mass trauma, top–down stabilization allows therapists to remain ethically and professionally oriented even when the external world is unstable. Without this orientation, bottom–up strategies may sustain biological survival, but not full clinical availability.

Middle Layers: Functional Stabilization (L4–L6)

Layers L4–L6 act as the bridge between bottom–up and top–down regulation. They hold the relational field (L4), the cognitive–narrative–predictive processes (L5), and the capacity for behavioral organization (L6). This is the level where closeness and structure meet, where the therapist can remain attuned without losing the frame, and keep the frame without losing attunement. In crisis contexts, the stability of these layers determines whether the therapist can act in an organized, clinically coherent way without disconnecting relationally from the client.

Functional Role of Vertical Configuration in Therapists

From a clinical perspective, the premise of VSM is clear: a therapist does not stabilize a patient through technique, but through the vertical organization of their own system. First, affective coregulation requires the therapist's system to be relatively stable across somatic, sensory, and emotional domains. A therapist working while chronically exhausted or autonomically dysregulated cannot modulate the client's arousal, their own state becomes part of the therapeutic field. Second, layers L3–L4 are especially vulnerable to transferential and countertransferential pressure. Vertical organization allows the therapist to recognize their own affect, to distinguish it from the client's affect, and to maintain boundaries without rigidity. It protects against what may be called emotional slippage: those moments when affect exceeds the system's capacity to regulate and integrate it. Trauma literature describes this phenomenon in different ways: affective flooding, collapse of the window of tolerance, loss of coregulation (Herman, 1992; Siegel, 2012; Tronick, 2011). Third, in high-intensity environments, war, evacuation, bombardments, long-term instability, the therapist must sustain lower--layer stabilization, relational presence, functional organization, and a sense of meaning all at once. Vertical orientation can distinguish regulation from mere survival, allowing continuity of clinical functioning.

Horizontal vs. Vertical Stabilization

Horizontal stabilization refers to the familiar toolkit: breathing exercises, sensory grounding, cognitive strategies, structured stabilization protocols. These remain useful, but their effectiveness is limited under prolonged, high-intensity stress. Vertical stabilization is not a technique. It is an organization of the therapist's entire system. It holds the body, affect, relationship, cognition, action, and meaning simultaneously. In this view, the therapist does not "use a tool." The therapist becomes the regulating system.

Observations from the European Room for Listening suggest that therapists who maintain vertical organization may be better able to sustain affective containment and reduce the risk of burnout and moral injury under conditions of prolonged stress. VSM makes visible a mechanism of stabilization that may remain effective even in extreme contexts.

Applying the L1–L8 Model: War, Crisis, and the European Room for Listening

The Necessity of a Layered Model in Chronic Trauma

Chronic exposure to trauma in wartime contexts reveals the limits of classical stabilization models that focus only on symptoms or affect regulation. Psychological disintegration under constant threat does not occur in a single domain. It affects the entire architecture of experience: somatic, sensory, emotional, relational, narrative, functional, existential, and cultural layers.

The L1–L8 model captures this multidimensional process by recognizing that therapists working under chronic stress operate simultaneously as:

- organisms regulating their own autonomic activation,
- relational beings exposed to coregulatory overload and vicarious strain,
- carriers of narratives, meanings, and values shaped by culture and transgenerational history.

War destabilizes the psychological system vertically. It activates two distinct vectors of dysregulation:

- bottom–up vector, typical for direct threats to life;
- a top–down vector, seen in long-term functioning within a chronically threatening environment.

Disruptions arise in autonomic regulation (L1), sensory overload and ongoing neuroception of threat (L2), affective dysregulation (L3), relational fractures (L4), narrative distortions (L5), functional disorganization (L6), and finally existential and identity crises (L7–L8).

For this reason, therapist stabilization cannot be reduced to a single level. It demands a vertical model that addresses the entire spectrum of experience.

Principles of Therapist Stabilization in Wartime Conditions

Literature on clinical work in disasters and humanitarian crises describes a wide range of coping strategies, but most focus on behavior or emotion (Hobfoll et al., 2007; Tol et al., 2011). The L1–L8 model allows us to formulate principles of stabilization grounded in vertical organization, from the lowest physiological layers to the highest layers of meaning and identity.

Somatic and Sensory Stabilization (L1–L2). The foundation of clinical functioning is the restoration of minimal autonomic regulation. During bombardments, blackouts, displacement, and chronic stress, therapists experience continuous micro-dysregulations that must be recognized and addressed in real time.

Affective and Relational Stabilization (L3–L4). The therapist functions simultaneously as witness, participant, and regulator. Stability requires not only coregulation with the client but, as seen in ERL, coregulation with an international professional community that provides additional relational safety.

Narrative and Functional Stabilization (L5–L6). On these layers, therapists regain

the capacity to create a coherent narrative in the midst of chaos and to maintain daily rhythms of clinical work. Dysregulation here leads to organizational collapse and impaired decision-making.

Existential and Cultural Stabilization (L7–L8). In wartime settings, therapists often draw on transgenerational resources, value systems, and spiritual narratives. These layers restore direction, meaning, and the ability to symbolically integrate overwhelming experience, allowing a movement from survival back to presence.

European Room for Listening as an example of vertical stabilization

The European Room for Listening (ERL) is an international support model that has been operating cyclically since 2023. It offers therapists working in conditions of chronic war threat a regular opportunity for regulation on multiple levels simultaneously. The ERL is not a therapeutic intervention or supervision, but a stabilizing vertical field that opens up conditions for stabilization.

Within the ERL:

- L1–L2: participants experience slowing down, grounding of the body, and reduction of sensory overload.

  Example: During one of the European Room for Listening meetings, one of the Ukrainian therapists said: "When I listen to others, I feel my body again… It hurts at first, but finally I know that I am alive." There was a noticeable slowing of breathing and a gentle equalization of tension in the group field as if the rhythm of the body had been synchronized between the participants for a moment. This brief episode illustrates the process in which the recovery of minimal somatic contact (L1) enables the transition to basic sensory and neuroceptive orientation (L2). It is at this level that the restoration of a sense of security, necessary for further regulation, begins.

- L3–L4: the group provides affective co-regulation and relational witnessing, reducing the isolation characteristic of war.

  Example: When tension in the group increased, participants returned to short rituals of shared silence. This simple gesture, repeated at each meeting, stabilized the pace of conversation and restored a sense of continuity. This is an example of L3 and L4 in action: shared silence and repeated ritual support affective co-regulation and relational continuity in the field.

- L5: shared narrative enables the symbolization of experience and the reduction of dissonance resulting from the geopolitical invisibility of war; L6: therapists regain functional rhythms of work, planning, and client care.

  Example: In one of the ERL meetings, a participant said: "When I talk about it here, the war ceases to be invisible. The words come back and I come back."

After this statement, the group began to share short descriptions of interrupted sessions and attempts to regain daily work rhythms. The shared narrative acted as a symbolic ordering of chaos (L5). This supported the recovery of functional rhythms of activity in the personal and professional lives of psychotherapists (L6).

- L7–L8: meetings restore meaning, professional identity, and a sense of belonging to an ethical community.

Example: In one of the ERL meetings, a therapist said: "My grandmother survived that war. When I am here, I feel that I am carrying on what helped her survive. Not only for myself, but also for my patients." In the group field, a frequent motif is the emergence of a clear sense of continuity, the rooting of experience in history and a shared destiny (L7). This moment helps restore the participants' existential-spiritual orientation. The awareness returns that their work has meaning even in conditions of chronic danger, and that they are part of a larger ethical community (L8).

In summary, the significance of ERL lies not in providing techniques to Ukrainian therapists working in war-torn areas, but in enabling vertical reorganization of experience in the presence of an international witness.

Relational witnessing as co-regulation of layers L3–L4

One of the key processes observed in ERL is relational witnessing. It is a form of presence in which international clinicians do not give advice, interpret, or evaluate, but jointly regulate affect and relationship in real time.

This process includes:

- affective synchronization (L3);
- confirmation of experience reducing the feeling of loneliness;
- a safe right brain to right brain relationship (L4);
- gradual recovery of the neuroception of safety.

Relational witnessing differs fundamentally from traditional social support. It is not based on the exchange of narrative content, but on experienced layered co-regulation. In war conditions, it is often the only space where therapists can regain a sense of existence in a relationship before returning to clinical work.

Transgenerational Resilience as a Manifestation of Layer L7

Analyses of narratives appearing in ERL indicate that many clinicians spontaneously refer to transgenerational resources. Family stories of survival, migration, resistance, or experiences of previous wars are recalled. In the L1–L8 model, this phenomenon corresponds to the activation of the generational-cultural layer (L7).

This layer has a stabilizing function because:

- it organizes experience in a broader cultural and historical context;
- it allows individual suffering to be anchored in a collective narrative;
- it restores continuity between the past, present, and future;
- it creates a bridge to the existential-spiritual layer (L8), where experience gains meaning and direction.

Discussion and Conclusions

The proposed L1–L8 model offers a layered framework for understanding therapist stabilization. It combines the neurobiology of regulation, the phenomenology of experience, and the framework of Positive Psychotherapy (PPT). Unlike the fragmented approaches dominant in the literature, which focus on regulatory techniques, well-being, or selected aspects of countertransference,

this model describes the structure of the therapist's experience as a layered system, organized vertically and rooted biologically, relationally, and culturally-existentially. This makes it possible to think about overload, regulation, and reintegration across different levels of experience, from physiology to meaning. At the same time, the L1–L8 model is not a closed system or intervention protocol. It is a proposal for a framework that organizes the understanding of therapeutic stabilization processes under high stress conditions.

Contributions of the L1–L8 model

The L1–L8 model contributes in three main ways to contemporary psychotherapy theory and practice. First, it shifts the focus from a repertoire of techniques to the layered organization of the therapist. Stabilization here is not the result of applying tools. It is the ability of the therapist-organism to return to the vertical axis, in which the somatic, affective, relational, narrative, and existential layers remain in dynamic integration. This shift is crucial in conditions of chronic threat, where access to techniques may be limited or ineffective. Second, the model links the four domains of PPT balance with the proposed architecture of experience. At the same time, it allows for their neurobiological and phenomenological clarification. Balance here is not an abstract category, but the result of the functional integration of specific layers (L1–L8). It enables the operationalization of concepts such as "contact," "achievements," "spirituality," and "body". Third, L1–L8 helps clarify clinical phenomena characteristic of work under chronic trauma. It helps clarify the dynamics of loss of neuroception of safety, narrative fragmentation, countertransference overload, and activation of transgenerational resources.

Implications for the education of psychotherapists

The L1–L8 model has important implications for the training of clinicians. First, it emphasizes the need for systematic training in somatic and sensory awareness (L1–L2) as the foundation of therapeutic presence. Recognizing autonomic and sensory micro-dysregulation should be a fundamental component of education, not an add-on to cognitive work.

Second, the model enables therapists to learn vertical ordering of experience. This facilitates clinical differentiation as to whether body stabilization, relational regulation, narrative reorganization, or meaning reconstruction is needed at a given moment in the therapeutic process. Third, L1–L8 offers a new approach to transference and countertransference, not as interpretative content, but as a layered phenomenon. Overload in one layer (e.g., sensory) can secondarily generate affective or relational disturbances, which has direct didactic implications.

Significance for supervision

In supervision, the L1–L8 model enables more precise localization of the point of overload in the sequence of layers.

Supervision based on this model:

- analyzes the process of dysregulation in vertical logic;
- identifies the layer initiating disintegration;
- supports a return to the vertical axis instead of focusing on competence assessment;

- facilitates the symbolization of experiences by working at levels L5–L7.

Supervision understood in this way may serve as a stabilizing and preventive process against burnout, especially in contexts of social and war overload.

Limitations and directions for further research

Despite its theoretical consistency and promising clinical observations, the L1–L8 model requires further empirical validation. Priority research directions include:

- qualitative research on the layered experience of therapists;
- evaluation of the effectiveness of vertical stabilization in different therapy modalities;
- integration with neurophenomenological methodology;
- operationalization of the model in education and supervision;
- research in high-risk populations (therapists in conflict zones, medical personnel, humanitarian workers).

The ERL documentation is an important starting point, but assessing the universality and scalability of the model requires research in different cultural and clinical contexts.

Significance for global mental health

In conditions of global crises: war, forced migration, humanitarian disasters, therapists often operate in the same field of danger as their patients. Classic models, designed for stable contexts, may prove insufficient in such situations.

The L1–L8 model:

- provides a language for assessing therapist stability in conditions of chronic stress;
- enables the design of vertical support structures, such as the European Room for Listening (ERL);
- allows for the description of phenomena specific to war (e.g., secondary trauma of geopolitical invisibility);
- integrates transgenerational resources (L7) and existential meaning (L8) as real dimensions of resilience.

This perspective is also consistent with the Leszno Declaration, which emphasizes the need for emotional and psychological support for psychiatrists, psychotherapists, therapists, and allied mental health professionals working in war-related settings, as well as for international collaboration and support structures for such work (Leszno Declaration, 2023)

In this approach, the ERL functions not as an intervention, but as a stabilizing vertical field that allows therapists to return to more integrated layered organization.

The L1–L8 model also suggests that transgenerational resilience is not only a narrative resource, but a dimension of experience that enables the therapist to return to clinical functioning in conditions of existential threat.

The analyses presented suggest that therapist stabilization should not be understood

only as a technical intervention, but as the clinician's positioning in the full continuum of experience. The key element is to restore the possibility of presence, regulation, co-regulation, and ethical readiness to witness both human suffering and human resilience.

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Table 1 *Ontology of Layers L1–L8 – The Vertical Model*

Layer	Name	Clinical Description	Typical Signs of Dysregulation	Function in Stabilization
L8	Existential Regulation	Meaning, values, spiritual grounding, and future-oriented orientation	Loss of meaning, collapse of mission, existential exhaustion, spiritual disconnection	Maintaining direction, coherence, ethical anchoring, and connection with something larger than the self.
L7	Cultural / Transgen-erational Regulation	Cultural, historical, and generational narratives; collective identity	Isolation, loss of continuity, cultural disconnection	Rooting experience in context, history, and shared lineage
L6	Functional Regulation	Execution, decision--making, planning, organization of clinical work	Hyperfunctionality, task-driven dissociation, rigid overperformance	Sustaining action and functioning under pressure
L5	Cognitive/ Narrative Regulation	Symbolization, narrative construction, and formation of predictive cognitive frames.	Survival narrative, cognitive narrowing, disconnection from lower layers.	Restoring coherent representation and predictive orientation.
L4	Relational Regulation	Coregulation, boundaries, attunement, responsiveness	Isolation, relational withdrawal, or excessive permeability	Maintaining clinical presence, empathy, and safe relational engagement
L3	Affective Regulation	Differentiation and modulation of affect; emotional resonance	Flattening, overload, emotional lability	Bridging soma and relationship; stabilizing affective flow
L2	Sensory / Neuroceptive Regulation	Sensory thresholds, neuroception of safety, environmental orientation	Hyperreactivity or numbness; loss of spatial grounding	Anchoring the system in the here-and-now
L1	Somatic (Autonomic) Regulation	Muscle tone, breath, autonomic rhythms, physiological baseline	Hyperarousal, shutdown, exhaustion	Foundation of the entire vertical architecture

Table 2 *Vertical Reorganization Flow (L1–L8): From Breakdown to Recovery*

Layer	Breakdown Pattern	Primary Reintegrative Move	Integrator Function (Transition)
L1 – Somatic Base	Autonomic dysregulation: hyperarousal, shutdown, exhaustion	Restore physiological rhythms (breath, pacing, rest)	Makes L2 accessible
L2 – Sensory / Neuroception	Hyperreactivity, numbness, loss of spatial orientation	Re-establish neuroception of safety; sensory anchoring	Opens access to L3
L3 – Affective Layer	Flattening, flooding, emotional instability	Affect differentiation; re-entry of emotional nuance	Allows relational engagement (L4)
L4 – Relational Field	Withdrawal, collapse of boundaries, empathic overload	Witnessed presence; relational coregulation	Restores platform for narrative organization
L5 – Cognitive – Narrative / Predictive Frame	Survival narrative, cognitive narrowing, loss of symbolization	Symbolization; rebuilding predictive and interpretive frames	Allows functional agency (L6)
L6 – Functional / Executive Layer	Hyperadaptation, automatic functioning, task dissociation	Reduce load; re-establish intentional action and agency	Opens access to cultural meaning
L7 – Cultural / Transgenerational Layer	Loss of continuity, isolation, rupture of lineage	Activate cultural and transgenerational resources	Leads naturally to existential reorientation
L8 – Existential – Spiritual Orientation	Loss of meaning, collapse of mission, existential fatigue	Reconnect with values, purpose, ethical and spiritual direction	Restores vertical coherence

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