Book Club: Agree to Disagree? A Conversation on 'Common Features of Psychotherapy'

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Release date:	Wednesday, 11th May 2022 on MHPN Presents
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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series. MHPN's aim is to promote and celebrate interdisciplinary, collaborative mental health care.

Dr John Cooper (00:17):

Hello, and welcome to Book Club. My name is John Cooper. I'm a psychiatrist who leads a youth mental health team in regional Victoria, and I also work part-time for Phoenix Australia, the Centre for Post-Traumatic Mental Health. For today's discussion I have, with permission, broadened the concept of Book Club to include a journal article. And today, we'll be discussing an article published almost 50 years ago. In doing so, I appreciate, I may be incriminating myself in terms of my age and also your age Mark, but in my defence, I reckon it was about 30 years ago when I first read it, and most of the things we'll be talking about are still very much relevant today. The article is titled Common Features of Psychotherapy. It's written by Jerome Frank. It's actually the transcript of a talk that he gave, and it was published in the Australian and New Zealand Journal of Psychiatry back in 1972. My guest today is Professor Mark Creamer. Mark, can I get you to tell us just a little bit about yourself?

Prof Mark Creamer (01:21):

Yes, John, and thank you very much indeed for inviting me to be your guest on this Book Club episode. So, yeah, my name's Mark Creamer. I'm a clinical psychologist in private practice, and a Professorial Fellow in the Department of Psychiatry at the University of Melbourne. And I've had a very, very long interest in the mental health effects of trauma in particular, and mental health more broadly as well. And so this kind of article, I think, raises all sorts of interesting questions for me, and I'm looking forward to our discussion.

Dr John Cooper (01:53):

Great. Thanks, Mark. Coming up, we'll be talking about common features of psychotherapy, and the impact that it's had on our thinking and our practice. My reason for choosing this article is that as a young psychiatrist, I felt it solved a particular dilemma. Early on, learning about all of the different psychotherapies, being impressed by the writings of the Freuds and Kleins, the Skinners and the Becks, I struggled with how, when it comes to solving the problem of human suffering, how could they all be right, and yet be so different? I was also slightly concerned about the guru factor, the cult of personality, and I wondered how that impacted on the way that we practice. So, when I read about the shared common features elaborated by Jerome Frank, that helped resolve these concerns and it led me to consider the merits of an eclectic approach to psychological treatments. I had met you, Mark, and you probably don't remember this, because you are getting on a little bit, but I met you in my final year of training while writing my dissertation on PTSD and veterans.

(03:07):

You were the local expert. You had done some groundbreaking research after the Queen Street massacre, and I was directed to you for some guidance in terms of my research. And then blink a couple of times, a few years later, you were my boss at what was then called the National Centre for PTSD. So, it was in our respective roles there that we had this discussion, or probably more like a polite argument. And the listeners need to understand, Mark, that whilst this was quite salient for me, when I raised it with you, you had no recollection of our argument. But nevertheless, you did make a strong argument against an eclectic approach. And I reckon that your arguments substantially shifted my thinking at the time. Now, we've continued to work in the area of post-traumatic mental health, as you mentioned earlier, and our paths regularly cross. I think it's worth noting that we're currently both working on a project to develop a centre of excellence for emergency service workers, their mental health in the state of Victoria, as part of our role at Phoenix Australia. So, Mark, have I sufficiently jogged your memory about what we talked about back in the mid nineties?

Prof Mark Creamer (04:30):

First of all, let me apologise for the fact that I don't actually remember this explicit argument. Having said that, the word eclectic always sets off flashing lights in my head, and I have no doubt that we discussed it on several occasions. And as you say, this is a general theme that keeps, I was going to say rearing its ugly head, but it keeps coming back and keeps being an important focus for discussion. But I do sometimes have some concerns, and I expect this is what we argued about, when we talk about being eclectic, that it really is just an excuse to grab a bit from here and a bit from there without really any coherent sort of theoretical or empirical kind of support. And so, I'm sure it would've triggered a reaction in me, reliably I'm sure, yes. But having said that, I do think a lot of what he says, we're probably going to agree on today, so.

Dr John Cooper (05:25):

Yes, yes. Now, I think my thinking at the time was that with all of our training, with the experience that we have, shouldn't we be adapting what we do to the needs of the patients that we're treating? It didn't make sense to me that the patient had to conform with, or agree with, a single theoretical approach, and seeing that all of the dominant theories and therapies have some merit. That was my thinking at the time that drew me to an eclectic approach. I thought that it was probably going to be good or even

better for the patient. You then introduced me to the rigours of evidence-based treatment, and I think that remains my starting point in thinking about this, and certainly from a clinical practice perspective. And I thank you for that.

Prof Mark Creamer (06:26):

My very great pleasure, John. I'm glad I had some influence. But yeah, look, I certainly have sympathy with the views that you express there, that I think it is important for us to tailor our treatments to the individual, to not assume we can just pull a step-by-step manual off the shelf and give the same to everybody. But I do think there's a big difference between tailoring treatment that still has a strong evidence base and a strong theoretical framework, from that to eclectic where we'll, as I say, take a bit from here and a bit from there. But yeah, I certainly wouldn't want to suggest that we should be too rigid in our approaches, yeah.

Dr John Cooper (07:06):

Good. Okay, well look, let's just sort of summarise briefly what Frank has written about in his article. I think it's important to acknowledge that he introduces his remarks as talking about this topic from a historical and a cultural perspective. So, he's not necessarily proposing sort of a hard scientific or empirical discussion. He acknowledges that while he's being published in the Australian Journal, that his remarks particularly pertain to the American scene, and really he was referring to the late 1960s and the early 1970s. So, we're thinking about towards the end of the Cold War, we're thinking about the end of the Vietnam War. We're thinking about all of the amazing and dynamic social changes going on at the time.

Prof Mark Creamer (08:04):

That's right. Can I pick up on that point?

Dr John Cooper (08:06):

Sure.

Prof Mark Creamer (08:06):

Because I do think it's an important one, that he was writing at that time, as you say. And he was really describing, I think, not only psychotherapy, behavioural psychotherapy and psychodynamic psychotherapy as it was in the 1960s, but also the state of psychiatry generally, or mental health generally. And I do think that there have been so many important developments that have driven changes in treatment and driven our understanding about how best to treat people. So many important changes since that time. I'd love to know how he would write this article if he was around today, whether he'd still stick with it. But I do think things like changes in diagnosis, we've progressed massively there, really. And our ability to perhaps fit more specific treatments to specific diagnoses.

Dr John Cooper (08:55):

Well, that's certainly where I think the article lands in terms of his recommendations, at the time, for the future. And interestingly, if we just look at the four groups that he described as being relevant to

receiving psychological treatments, he spoke about those with existential concerns, that we might call the "worried well", he spoke about those who are normally and usually well but might be temporarily overwhelmed by the crisis or the trauma that they've just gone through. He referenced the chronic serious mental illnesses that some people experience, who are likely to require medical treatments, but medical treatments alone clearly being insufficient. And then his fourth group were a little bit harder to sort of clarify. And I suspect that's because, at least in my mind, because I think the language that he used had particular relevance to when he was writing. But my interpretation is, he's talking about those with developmental trauma or early other sort of experiences that we consider causative of mental health problems. And I suspect, if he was writing today, he'd be talking about attachment kind of difficulties as one of the elements of this group.

Prof Mark Creamer (10:21):

He might be, yeah. And I'd like to go back through those groups, actually. But just on that point, the group of what we would consider high prevalence conditions, so our anxiety disorders, our depression, perhaps our substance use, certainly our PTSD, I think really all of those, they certainly don't fit into any of the other three groups. So, I think essentially, he's kind of lumping them there. And I think it's a slight pity that he's gone to an etiological formulation and saying, this is the group that because of early childhood experience or whatever, if we understand it more from a contemporary diagnostic perspective, those high prevalence conditions, I think we'd have to fit in there. And I think he's saying really, isn't he, that this is the only group of the four that psychotherapy is really cut out for. He says in the first one, I don't know if he actually says it or maybe I misread it, but he basically says this first group who are sort of looking for the meaning of life and so on, they'd be better off going and joining a religious cult, kind of thing. Something like that.

Dr John Cooper (11:22):

I'm not sure that that's quite, I think, I read it as he distinguished between folk who were clinically trained in mental health conditions and in the therapies as not being needed for this group, that more general counsellors or less trained folk could easily satisfy the needs. I think with the crisis group, he basically said, and again, this is my misrepresentation, anybody capable of giving them a nice warm hug and a cup of tea.

Prof Mark Creamer (12:04):

I think he does say caring, stable kind of people. Anyone can do it.

Dr John Cooper (12:06):

And yes, so I think with that fourth group, that we would consider the high prevalence disorders, I think he said that that's probably where we should be able to finesse the therapy for the presenting problem.

Prof Mark Creamer (12:22):

I think that's right. Just to come back to the third group, which is our chronically unwell kind of people, he's also a bit dismissive there, in the sense, I think he says these can be looked after, essentially, by non-professional people who are supervised by professionals. And we talked a minute ago about the

kinds of developments that have taken place since he wrote this. And I think now we would say, even with that quite chronic group, we have quite a lot to offer in terms of modern approaches to things.

Dr John Cooper (12:50):

Yes, I think he references anything that boosts morale will do. So, if we just, I think in providing the listeners to the Book Club, just a clearer sense of what Frank was describing as the common factors, six of them. The first one is that there is an intense emotionally charged confiding relationship. Should

Prof Mark Creamer (13:16):

Should we take them one at a time?

Dr John Cooper (13:17):

Okay.

Prof Mark Creamer (13:18):

Is that right?

Dr John Cooper (13:19):

Yep. Well, actually, let's go through them and then we'll go back so that...

Prof Mark Creamer (13:22):

You're the boss, John.

Dr John Cooper (13:22):

No, no. So the Book Club listeners know where we're going.

Prof Mark Creamer (13:26):

Yes, good idea.

Dr John Cooper (13:27):

The second one is to have a rationale or myth that provides an explanation and solution to the patient's problem. The third is the provision of new information to help explain and solve the problems. The fourth is strengthening the patient's expectation of help through the personal qualities of the therapist. The fifth is providing success experiences that heighten hope and enhance mastery and personal competence. And the final one is the facilitation of emotional arousal. And just in response to that, he does write a little bit about abreaction, and some of those methods that have facilitated these strong emotional responses. So, going back to the first one, an intense, emotionally charged confiding relationship,

Prof Mark Creamer (14:17):

A strong therapeutic relationship, essentially. And just as an overview, I think it's interesting how many of these now actually do have empirical support for them. So, he was definitely on the right track. But yeah, so I think a strong therapeutic relationship is really important. And as you know, but the listeners may not, my background is unashamedly in behavioural and cognitive behavioural kind of approaches, and certainly in the early days, and I think really when he was talking, there would be this assumption that behavioural psychotherapy has nothing to do with the therapeutic relationship, because we're working with rats and so on. But the reality is, of course, that it's absolutely vital. And there was that classic experiment, wasn't there, where they had three well-known therapists of which one was Carl Rogers, Mr. Empathy himself, and one was Joe Volpe, who's a very well-known behavioural, early behavioural psychologist. And they asked independent raters to rate the level of empathy of these three. And lo and behold, Joe Volpe came up number one on empathy. So, strong therapeutic relationship, I'm not going to argue with for a minute. I think it's really important.

Dr John Cooper (15:17):

And if you look at it from the perspective of the person seeking help, clearly, if you're going to come back a second time, there's got to be some element of that there.

Prof Mark Creamer (15:28):

Absolutely.

Dr John Cooper (15:29):

Absolutely.

Prof Mark Creamer (15:30):

Yeah.

Dr John Cooper (15:33):

The rationale or myth, and he expands and qualifies his reference to myth. What do you think about that? Because I think that the language that I would tend to use would be, in the early stages of a clinical assessment forming, through a formulation, a hypothesis, a hypothesis that's informed by the perspective, the theory, the understanding of the approach. I don't think that's exactly what he means in his reference to myth. And in some respects, he's actually shooting down what he calls or means is a pseudoscience underpinning a number of the psychotherapeutic approaches?

Prof Mark Creamer (16:31):

Yeah, I mean, I think that this point about giving your client or your patient a rationale sort of underpins several of the others that we're going to talk about in just a minute, actually. But yeah, look, I do think it's important to give them some kind of understanding of where you're coming from, and how you're going to work together on these kind of problems. I well remember in my early training reading some work from a guy called Donald Meichenbaum, who was one of the early cognitive people really, not too

long after this article was written. And he talked about this, the importance of the rationale. I remember him saying that the actual truth or the factual accuracy of the rationale is not nearly as important as its credibility for the client. And if it makes sense for them, then you've kind of engaged them and you're starting off on the right kind of path. So yeah, look, I'll go along with it, I think.

Dr John Cooper (17:23):

From a CBT perspective, or really a more general perspective, aren't we just talking about psychoeducation here?

Prof Mark Creamer (17:31):

Well, I noticed that's his next one really, isn't it? I'm going to talk about that. To a certain extent we are, but I guess there are elements of, I think you can go beyond that a little bit to explain a bit more about how things developed, and how that relates to how you're going to work on it. I use lots of diagrams, and pictures, and so on. But anyway, I quite agree. Talk about the next one, because I think you're right, it does lead into it.

Dr John Cooper (18:00):

So, provision of new information to help explain and solve the problems, that really follows from the previous one. A person needs to have a reason to do what you're suggesting as part of the solution, and the experience of a patient saying, well, I've done that. I've tried that. I've been told that. How do you move them from that position to understanding that there is, in fact, a way forward that has a reasonable chance of being effective? It means giving them some hope that you can bring something to bear that maybe the three previous people didn't do.

Prof Mark Creamer (18:45):

And of course, it's particularly important in our field, isn't it, in the trauma field, where really what you're asking them to do is the worst thing. I mean, exactly what they don't want to do, is go back there and revisit this stuff and we're telling them, no, actually this is really important. So, having some kind of rationale as to why we might do that is crucial. I also think, another thing that just springs to mind, we're talking about psychoeducation or this sort of area, is the fact that we've kind of got a name for it, we've got a label for it. The people come in thinking, I'm the only person in the whole world who's going through this. And you can say, actually, we've worked with a lot of these people, we understand it, and here's, we've got a name for it. We can call it whatever it is, PTSD or OCD or whatever. That can sometimes be very reassuring for people, I think. So, in that sense, I think psychoeducation is also helpful. And I think we are probably, the risk of moving on to therapy, but there are some very simple things that I would put under the heading of psychoeducation, around things like lifestyle, simple stuff about looking after yourself and getting plenty of rest and so on, that they're not really therapy, but they're really good and sensible, and exercise is very important and things like that, that we could put under here if we wanted.

Dr John Cooper (20:01):

But surely before you go anywhere near, say, an exposure exercise with a patient, you've given them a very explicit rationale. You've given them information about the likelihood of success. You've told them

that there's going to be high levels of distress, but it's going to be controlled. It's going to be managed in a way that is likely to allow them to feel the benefit down the track, to improve their functioning, their quality of life. That's part of our spiel, I mean, before we can go anywhere near that.

Prof Mark Creamer (20:43):

Yeah, absolutely right. And we might come back to this on number six really, where he talks about reaction. But yeah, I think perhaps more so when we're using a technique like prolonged exposure, I mean, we should do it all the time, but it's particularly important for there, I agree.

Dr John Cooper (20:58):

Well, certainly from a medical perspective, I'm disappointed and surprised when I encounter patients who've been given no information about their medication. And this rationale and the myth I think is equally relevant to the prescription, because we have multiple different biological theories as to why people get depressed and how antidepressants work, for example. So, I see that some of these elements are really core to good practice and psychological interventions clearly benefit when they're done well.

Prof Mark Creamer (21:45):

Exactly. And presumably, as you allude to, pharmacological as well, actually. Anyway, let's move on to number four. What was number four?

Dr John Cooper (21:53):

Number four is patient's expectations of help. So, it's around giving them the confidence that we know what we're doing as the therapists and the practitioners, that we've done it before. I think this is sometimes quite difficult for younger clinicians, but how does that work?

Prof Mark Creamer (22:18):

Yeah, well, I think certainly I was alluding to the fact that a number of these have now been born out by empirical support, and there are a number of studies looking at how expectancy, positive expectancy links into outcome. And I remember being told once early on in my career that as a good therapist, a big part of your job is being a salesman. It's actually convincing them this is going to work. And so, I suppose that, I mean, what it does do I think, is it helps to improve engagement and ensure engagement, ensure commitment, because they believe that it's really going to work if they put themselves into it. I think it's probably along those lines, yeah.

Dr John Cooper (22:58):

Because it's interesting, the personal qualities of the therapist. If you think about the dominant paradigm before this was written, and that's sort of a psychoanalytic or psychodynamic paradigm, the personal qualities of the therapist were often quite opaque, and a lot of that was sort of left to the patient to either invent or discern for themselves. But even that seemed to be or seems to be part of the therapeutic potency there. The personal qualities of the therapists, how we think about that in the context of boundaries. So, I think there's information that patients have about our qualifications. We get

referrals, so the people referring are giving information. But why does one patient turn up once and doesn't come back again, and another person turns up and says, yeah, let's go.

Prof Mark Creamer (24:15):

Yeah, I don't know. I mean there's a whole range of explanations, I suspect, very individual kinds of things. But I think we have to accept the fact that we all get on well with different people. And I often tell people, if you don't feel that we are a good fit, that's fine. I'm not going to be offended at all. You find someone who you think you're a good fit with, it's fine with me. But I think this whole thing about the therapist's kind of charisma or whatever it is, it taps into what you started off at the very beginning talking about, gurus and so on. And there's no doubt that throughout the history of psychotherapy in the broadest sense, there have been these people who seem to get remarkable results, as you say, doing completely different things. And how much of that is due to their charisma and their guru status, I don't know. It's certainly a factor, isn't it?

Dr John Cooper (25:08):

Number five is the provision of success experiences that heighten hope, and enhance mastery and personal competence. And this just seems to me to be a fairly clear advertisement to what happens in cognitive and behavioural therapy.

Prof Mark Creamer (25:24):

I'm so glad you said that, John, because if you hadn't, I would've done. But I think you're right, I do think that CBT is ideally placed to give some early quick wins, and to help the people feel reasonably quickly, they're beginning to get some mastery.

Dr John Cooper (25:41):

Well, I think the cognitive behavioural approach for depression is around activating people into things that they enjoy, and that they're good at. So, that's clearly going to be a more straightforward step than asking an anxious person to do an exposure therapy.

Prof Mark Creamer (26:02):

But with our anxious people, of course, we have techniques or strategies that we can give them around whatever, controlled breathing.

Dr John Cooper (26:10):

It also goes to the importance of between session work that is a core part of a cognitive behavioural approach. The homework, the in vivo work, the readings, the monitoring, the whole package seems to be well encapsulated in this particular point that he's making.

Prof Mark Creamer (26:32):

I think it's a very good point, isn't it? And I do think that, not suggesting for a second that CBT is necessarily the only one to do it, but it does take a very collaborative approach. We're working together

as distinct from the more traditional models, where you go to your doctor or whatever, and the doctor does something to you, or gives you something, where you don't really have a great deal of control. And as you say, no responsibility during the week to do anything, as long as you take your tablets or whatever. Whereas yes, the CBT approach is very different. And I think by adopting that collaborative approach and engaging the person themselves as an agent in their own change, I think it adds to the power, independent of anything else that you might do.

Dr John Cooper (27:15):

And then finally, the facilitation of emotional arousal. And I think that has to lead into some of his discussion around abreaction.

Prof Mark Creamer (27:25):

It does, which we will go onto John, but even without abreaction, I do think that it's kind of worth recognising that effective therapy is a bit painful. You're always going to be dealing with something difficult. That's the nature of why the person's sitting in front of you, and if you want to come in and have a nice hour, we can chat about the football or whatever, but you're not going to get any better. So, I do think that some kind of emotional stuff is inevitable. And then as you say, yeah, go on then. Abreaction, yeah.

Dr John Cooper (27:52):

So, let me be a little bit provocative. Abreaction, prolonged exposure. What's the difference?

Prof Mark Creamer (28:02):

Well, I think abreaction carries a whole lot of history with it. It carries, actually, a theoretical kind of model, which we wouldn't necessarily agree with, but also a whole lot of baggage and history and so on. But, what's the difference? Well, I do think the difference is, and you alluded to this earlier in what you might tell your clients, that prolonged exposure is a much more controlled process. So, the person is in control, it's step by step, hierarchically going through it in a collaborative kind of way, and so on. Whereas I do think abreaction traditionally tended to be quite uncontrolled, often chemically facilitated, and often did prove to be, I think, a terrifying experience for the poor person going through it. So, we're not that mean anymore. And I don't think it worked that well, really.

Dr John Cooper (28:48):

But it's been, I mean, Frank will argue that it's been a fairly recurrent feature of different paradigms and different approaches. And look, I've been around long enough in the early stages to have actually witnessed some attempts at abreaction, pharmacologically and through hypnotherapy. And, done well, I don't actually recall them being incredibly uncontrolled. The clinicians, the therapists were skilled, they were mindful of the fact that the session had to end, that the patient had to function afterwards. And whilst the textbook descriptions of abreaction have that uncontrolled element to it, I think there were some of the strategies that are used in say, prolonged exposure, where you're looking to have SUDS go up to eight out of 10 or whatever, and kept there, high levels of distress. I reckon in good therapy that controlled factor, that safety factor, is always there.

Prof Mark Creamer (30:06):

Yeah, okay, look, I'll certainly pay that. And that's the criteria in good therapy, however we want to define it, that I'm sure that abreaction, whatever that is, it's just a word, but when it's done well, it doesn't look that different. I quite agree. And equally, there are some horror stories about people doing exposure in a very uncontrolled kind of way as well. So yeah, so I agree that there is a big overlap. What I would say is, perhaps, that now it comes back to what we were saying earlier, that the process, prolonged exposure now has a strong body of research about how best to do it, and also a strong theoretical framework underpinning it, particularly around not only habituation, but also around emotional processing, information processing kind of stuff. So, I think perhaps that's a bit of a difference, but yeah, look, essentially, I'm prepared to give it a bit of ground there. Yes. So, that's the six, isn't it?

Dr John Cooper (31:03):

That's the six.

Prof Mark Creamer (31:04):

And I don't really disagree, I'm not going to fight over any of those. What I am going to fight over is whether that in itself is enough, and really, whatever else you do doesn't matter as long as you've got those six, then the person's going to get better. That's where I'm going to disagree, I guess.

Dr John Cooper (31:19):

So, what are the elements then, beyond the six?

Prof Mark Creamer (31:27):

I think that it comes back to what I was saying earlier, in terms of better diagnosis and therefore more sophisticated kind of treatment matching. And so, for example, you mentioned yourself depression, that if we've got someone who's depressed, even if we do all these kinds of things, some of them will get better, but without things like some behavioural activation, which is sort of fundamental really, and perhaps without some kind of cognitive restructuring, you're going to get much more limited effects. And similarly with anxiety, without some kind of exposure to the feared stimulus, without those kinds of things, I'm interested that he says, and he kind of says it in a throwaway kind of statement, he talks about modelling rewards, extinguishing fears through repeated exposure, variance of abreaction. So, he's kind of acknowledging that there are things we can use, there are tools if you like, or techniques that are going to improve our outcomes. And that's where I think it's really important.

Dr John Cooper (32:35):

In thinking about this and reflecting on my own work and experience, I can recall telling my juniors and registrars that the older that I get, the more behavioural I get. At the end of the day, whether it's a pill or a cognitive strategy or an interpretation, if it doesn't lead to behavioural change, what's the point? The behavioural change that leads to improved functioning, which in turn leads to improved quality of life. So, what's the best way to get that change, that behavioural change. And that behavioural change I think also works at a relationship level. We see a lot of the problems that our patients experience impact

adversely on relationships. Changing behaviour within relationships is another example of the benefits. And if we can straighten somebody's distorted cognitions, or if we can link a maladaptive response to a childhood experience, does it matter if it then ultimately leads to that behavioural change?

Prof Mark Creamer (33:57):

I think you're absolutely right, actually. And I think that there are probably a number of different ways to get there, many of which have evidence for them. But I quite agree that really, we share that end goal. And I tend to agree with Frank, that if we can bring in those kind of six things, that's great, I think. Yeah, good.

Dr John Cooper (34:21):

Alright. Well look, I suspect that we're nearing the end of our time. I just wanted to go off on a slight tangent before we finished, and I was taken a little bit by his account of the historical aspects of the way treatments and therapies have evolved over time. He contrasted the psychodynamic approach that might reflect an earlier time, maybe from Europe, a more paternalistic authoritarian approach, to what was different in the more, at the time, modern American experience. And he spoke about the culture being characterised by a pragmatism and a gregariousness, and he linked the pragmatism to the commencement of the behavioural therapies, practical here and now. And he linked the gregariousness to the burgeoning group therapies that we haven't really touched upon, but were probably raging at the time that he wrote this. What do you think the impact of our current place in history, and the cultural changes that might have arisen out of the internet, social media, the things that are having dominant influences today, how do we characterise ourselves today as a society and what's the relevance of that to the way we practice?

Prof Mark Creamer (36:01):

I wish you'd given me some warning on that one, John. Throw that at me in the last minute!

(36:07):

I do think that we could say this at any stage in our history, I suppose, but the fact is society is changing very fast, isn't it? And I think that it's really hard to underestimate, I think, the impact of the internet, but more particularly social media, and how that changes the way people not only relate to each other, but very importantly, feel about themselves and judge themselves and so on. So, I do think that that's going to be kind of, a bit of a defining feature. So, we in mental health, I think, have to be part of that, and we have to adjust the way we work, I guess, to fit in with that and so on. And I'm rather glad I'm sort of coming to retirement, John, because social media and me don't get on at all.

Dr John Cooper (36:54):

That's right. Look, the fact that we're doing Book Club via podcast, I think that's probably testing us, taking us to our limits.

Prof Mark Creamer (37:01):

And you've got your pipe and slippers there.

Dr John Cooper (37:05):

I think we're going to have to depend upon younger folk to answer some of these questions and move the field forward. I suspect this stuff is going to remain core and central to good practice, but I think going forward it's going to look a lot different.

Prof Mark Creamer (37:20):

I think you're right, I think you're right. And it will be interesting to see how many of these six principles stand up and how many could be massaged away, if we've got a computer doing it instead of a human being. But time will tell.

Dr John Cooper (37:35):

Yes. But yeah, so apps, web-based therapies, podcasts, yeah.

Prof Mark Creamer (37:43):

It's an exciting time, really.

Dr John Cooper (37:44):

It is, it is.

Prof Mark Creamer (37:45):

You're absolutely right. We have to leave it to someone else.

Dr John Cooper (37:47):

Did you have any other final remarks, or comments about the article before we finish?

Prof Mark Creamer (37:55):

I don't think so, John, except to say that I'm glad that you asked me to be part of it, because this is a paper that I would've forgotten about completely. So, being forced to read it again and so on, it was a very interesting experience. And it is an interesting article, and I'd certainly recommend it to listeners. It's quite short, but well worth having a read if you get a chance.

Dr John Cooper (38:15):

Yes. And interestingly, I guess a confession towards the end, is that when I was approached about the Book Club, I had conflated in my memory this article and Frank's book, Persuasion and Healing. And I have it on reliable information that in fact, that will be a future podcast for the Book Club, around the book.

Prof Mark Creamer (38:43):

Well, that will be interesting, to see what their take is. We mustn't allow them to listen to ours before they do theirs.

Dr John Cooper (38:47):

That's right.

Prof Mark Creamer (38:47):

But yeah, that'll be interesting, to see their take on it.

Dr John Cooper (38:51):

So, that's something for the listeners of the Book Club to look forward to. You've been listening to Mark Creamer and John Cooper. We'd like to hear from you about your thoughts on this particular episode, as well as any ideas for content for future episodes. For any information on what we've discussed in this episode, please check the show notes. Make sure you tune into the next episode of the Book Club. And thanks for listening. So, it's goodbye from me, John Cooper.

Prof Mark Creamer (39:18):

And goodbye from me, Mark Creamer.

Dr John Cooper (39:21):

Thank you.

Host (39:23):

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