Chapter 1: Introduction

> *"Lived-body is experienced as true self, as being thoroughly and spaciously aware of one's embodiment from moment-to-moment – sensing precisely the body sensations, feelings, and thoughts which give form and meaning to each living moment. From the perspective of body/mind psychology, it is this experience of being grounded in the flesh and blood body which provides the precondition for an alternative set of possibilities as to how we live, love and heal ourselves".*

This quotation from Marrone (1990: p 15), an educator, a researcher and a psychotherapist, is very meaningful to me personally as I feel it captures perfectly my own interest about the subject of this research. I would like to explore the relationship between the psychotherapy and complementary therapies and the ideologies guiding the respective professionals' work, including everyday decisions informing their interventions.

Marrone's (1990) insightful words tick a lot of key concepts and themes surrounding my interest in the subject, namely, 'experience', 'self', 'awareness', 'embodiment', 'feelings', 'thoughts', 'meaning', 'living moment', 'body' and 'healing'. This being systemic research, my interest in the subject is rooted in my own beliefs and relational experiences, from which I form my own opinions and biases. From encounters I have had with people along the years, both in a professional capacity and in what I have learnt from various significant persons in my everyday life, I have come to believe that emotional or family problems, for example, could get manifested in functional somatic symptoms. A person may become ill without any apparent medical reason. My interest lies in how the mind, the body and the emotions are dynamically interrelated; and in how the experience, including physical stress, emotional injury and pleasures, is stored in the body's cells which in turn affect one's reaction to

different stimuli. Moreover, I am interested in effective therapy approaches and collaborative ways grounded in systemic thinking, attachment theory, the language of the body and neuroscience, which provide support to people experiencing issues like physical and emotional stress.

This research is a first step in exploring all this but it is also borne by personal interest. Whilst I am getting closer to completing my studies and graduate as a psychotherapist, my partner is a complementary therapist. Through our relationship for the last seven years, I have learnt a lot about the value of complementary therapies. Along the years, I have been learning about the effectiveness of both forms of therapy in different ways. I have witnessed the effectiveness of systemic therapy through my own clinical practice under supervision.

At the same time, I have also heard different accounts of people describing their registered progress in their well-being through complementary therapies like Aromatherapy, Reflexology, Massage Therapy, Acupuncture, Osteopathy, Homeopathy and more, in cases like sciatic and back pains, fibromyalgia and carpal tunnel syndrome. I have also been a client of both therapies and experienced that same positive sentiment personally. I can see how both professions and disciplines converge in the way they support clients who are in need of change in their lives, even though they obviously differ in their methodology.

As my interest in both fields intensified, I wanted to learn more and widen my own perspectives through researching the subject. I was very much curious of how the two professions and disciplines complemented each other, if at all, as well as how they both conceptualised problems and change. With psychotherapy clients increasingly using complementary therapies, and with complementary therapy clients seeking help in

psychotherapy, as research reveals, I feel it is necessary and important that one looks closer at a possible integration of the two professions and disciplines in the Maltese context.

Although research on the holistic connection of mind and body has increased significantly over the past decade through contributions by Damasio & Damasio (2006); Simon & Chard (2014); Larner (2016); and Kozlowska (2016), just to mention a few, primarily where physical illness is concerned, there have been few studies which looked at this integration to address psychological problems. While there has been research focused on complementary therapies, like that of Kessler et al. (2001) and Bassman & Uellendahl (2003); and research like that of Elkins et al. (2005) reporting statistics of use of such therapies by psychotherapy clients in America; no research was found to have examined the benefit of the simultaneous use of both therapies.

Moreover, I did not find studies aimed to explore whether or not the combination of both forms of therapy more adequately addresses the client's presenting problem. Furthermore, little is known about whether or not complementary therapies enhance or facilitate the psychotherapeutic process. Thus, in order to explore the relationship between the two professions and disciplines, and the ideas behind them, for the purposes of this research, I am trying to answer the following research questions: How do the two professions and disciplines complement each other? What do the respective professionals know about each other's profession and discipline? What are their ideas of problems and change? Do the professionals within the two professions seek each other's therapies and do they refer clients to each other's form of therapy? In an effort to contribute conceptually and practically to both professions and disciplines, this research will be a step forward in exploring the relationship between complementary therapies and psychotherapy.

To contextualise this line of thought, in my opinion, the traditional medical model in Malta is still very strong, and getting the diagnosis is still sought by clients. It seems that people are still very much inclined to go to medical doctors as soon as they notice the slightest of symptoms of physical sickness in order to obtain a medical prescription. A review of Europeans' antimicrobial resistance published by the European Commission last year, for example, shows that nearly half of the Maltese population consume antibiotics to treat symptoms and ailments that the medication could not cure (Times of Malta, 2016). The same goes with Maltese seeking psychologists and psychiatrists when facing anxiety in distressful times, as revealed in the extracted data of the mental health and related issues statistics by the European Union (Statistical Office of the European Communities, 2017).

In fact, looking at the local Maltese context, a lot of people speak of "feeling" or "being" depressed, with the term 'depression' commonly misused in everyday conversations to refer to widely varying conditions including sadness, anxiety, stress, obesity, loneliness, failure, loss, and bullying. People's understanding of illness and healing seems to be very superficial. When they experience symptoms of illness, they look for a quick fix, often not resolving their issue satisfactorily, resulting in more symptoms without solving the issue at source by breaking the circular pattern through doing something different. Just turning to medical advice and seeking medicinal prescription without trying to understand one's body, one's emotions and thinking processes, makes way for the need of self-growth and connection with one's self.

This context is indicative of the Maltese people's embedded culture, the way I perceive it. Consequently, I would like to investigate the openness of the Maltese people to these

different therapies, namely psychotherapy and complementary therapies, starting from the ideas and perspectives of the professionals involved in both professions and disciplines.

1.1 Clarification of terms

For the sake of this study, which is looking at the relationship between psychotherapy and complementary therapies and the respective professions and disciplines, it is important that at this stage, I clarify the term 'complementary therapy' which I will be using throughout this study.

In the majority of research I will be referring to, authors use the acronym CAM, standing for Complementary and Alternative Medicine. Other authors also use a variety of terms including complementary, alternative, holistic, natural, unconventional, non-traditional, and integrative medicine, and have also defined the two terms differently (White, 2000).

The terms 'complementary' and 'alternative' are not interchangeable. Complementary refers to treatments 'thought of' or used 'together with' conventional medicine. Alternative medicine is used 'in place of' conventional medicine (NCCAM, 2002; White, 2000). True alternative medicine is uncommon. Most people who use non-mainstream approaches use them along with conventional treatments (NCCIH, 2016).

The definition of 'CAM' comprises a wide range of therapies. Those therapies considered to be 'CAM' change from time to time with the emergence of new approaches declared safe and effective in conventional health care (NCCAM, 2002). Moreover, the treatments that are included under the term 'CAM' can vary from one source to another (Muskin, 2000).

The NCCAM has classified the different forms of 'CAM' into the following five categories, namely, Alternative Medical Systems (e.g. Homeopathic Medicine, Naturopathic Medicine, Traditional Chinese Medicine...); Mind-Body Interventions (e.g. meditation, prayer, Dance, Art and Music Therapies...); Biologically Based methods (e.g. Dietary supplements, Herbal therapies...); Manipulative and Body-Based methods (e.g. massage, Osteopathy, Acupuncture...); and Energy Therapies (bio-field therapies like Qi Gong and Reiki; and bio-electromagnetic-based therapies like Magnet therapy).

For the purpose of clarity, in this study I will use the term 'complementary therapy' to reflect how the therapies listed above are culturally referred to in Malta, by the same therapists practising them. As for the term 'psychotherapy' which I will also use throughout this study, one would need to keep in mind that there are different psychotherapy approaches varying from psychoanalysis and psychodynamic to systemic, behaviour, cognitive, CBT, humanistic, Gestalt, and existential approaches.

Chapter 2: Literature Review

The 1966 work of Berger & Luckman, entitled the *Social Construction of Reality: A Treatise in the Sociology of Knowledge*, was employed as the lens through which as the researcher I will look at research aiming at retrieving the social and psychological understandings linking people, place and physical activity. It is also on these lines that as I explain in the methodology chapter, this research adopted a social constructionist framework.

At the very initial stages of my literature research, I came across an article published in the July/August 2005 issue of the Clinical Medicine Journal of the Royal College of Physicians, with the following title: *A tale of two therapies: psychotherapy and complementary and alternative medicine (CAM) and the human effect*. I could easily see how this study was very much in line with my own area of research and helped me set the tone for this literature review.

The author, Michael Hyland, a professor in health psychology at the University of Plymouth, says that meta-analyses show that psychotherapy and complementary and alternative medicine are effective primarily or entirely due to contextual factors rather than the specific disease-treating factors suggested by the therapy (Hyland, 2005). He explains that they both provide a context that enhances the clients' ability to self-heal. Adding that therapists are the most important contextual factor, he says that psychotherapy research shows that therapist effectiveness varies from zero to about 80%, but has failed to identify what makes a good, charismatic, therapist. He declares that therapist effects are unrelated to experience or training or type of therapy. He adds that in CAM research, the effectiveness of therapies on psychological outcomes is unlikely to be caused by the physical effect of manipulation but is

due to factors common with psychotherapy. In his own words, “the conclusion that CAM and psychotherapy are effective due to the human effect leads to more questions than it answers. We do not know what charismatic therapists communicate to patients, we do not know the mechanism of communication, and we do not know how this communication influences the patient therapeutically”. The author affirms that the therapist does matter, but it is not clear how or why. He also states that we need a better understanding of the effects of the therapist in all forms of therapies (Hyland, 2005).

Interestingly, the same emphasis on the therapists as the most important contextual factor, featured in other pieces of literature. As a systemic trainee therapist, this triggered more curiosity within me. Saul Rosenzweig (1936), who became well known after publishing a paper on the "common factors" underlying different approaches to psychotherapy, was the first to assert that there are common components like therapeutic alliance and clients’ positive expectations in his research on the effectiveness of treatment models (Sprenkle & Blow, 2004). According to Sprenkle and Blow (2004), the common factors are variables of the treatment setting that include the client, the therapist, the relationship, the expectancy, and the techniques that are not specific to a particular model. These factors establish the core ingredients and commonalities that are shared by different therapies (Norcross, 1999).

It is alleged that it is these commonalities which bring about change in therapy, not the specific techniques of the individual models (Hubble et al., 1999). Referring to psychotherapy modalities in general, in his foreword to the book ‘*The Heart & Soul of Change: What Works in Therapy*’, Norcross (1999) says that he believes that the common factors contribute to the complex therapeutic process. He states that “common factors are not located solely in the therapist but also in the client, not solely in the intra-therapy alliance, but

also in the broader environmental context; not solely in formal treatment, but also as part of clients' self-change" (p. xix). Reflecting on the common factors referred to above, I could picture a possible relational aspect between the psychotherapy and the complementary therapies.

2.1 Complementary Therapies: Their use in healthcare

Researching through different online academic libraries both psychotherapy and complementary therapies separately and together, I was curious to see if and how complementary therapies were featuring in healthcare systems around the world. I aimed at equipping myself with more knowledge in this area as, coming from the psychotherapeutic setting; I wanted to explore how other countries might differ from Malta where psychotherapy and complementary therapies and the respective professions and disciplines are barely discussed.

Along the years, especially from the early 1990s, in consistence with an increase in use of complementary therapies in the USA, various health professionals surveyed the role of these practices in their respective fields, including mental health. Studies by Astin (1998); Barnes, Powell-Griner, McFann & Nahin (2004); Eisenberg et al., (1993), Eisenberg et al., (1998); Paramore, (1997); Rafferty, McGee, Miller & Reyes, (2002) report that an acceptance of complementary therapies by people in general was clearly indicated. Such therapies seem to be most frequently used for non-life-threatening chronic conditions like for example back pain, depression, stress and anxiety, headaches and fatigue (Bausell, Lee & Berman, 2001; Eisenberg et al., 1998; Elkins et al., 2005; Kessler et al., 2001). Similarly, though, it has been shown that those with declining health are more likely to use complementary therapies

(Astin, 1998), as are those who are chronically ill with conditions such as cancer, chronic pain or AIDS (Hyland, Lewith, & Westboy, 2003).

Another clear indication from research was the need for better professional preparation and more extensive efficacy research to support the inclusion and utilization of complementary therapy practices (Brolinson, Price, Ditmyer & Reyes, 2001; Hessig, Arcand & Frost, 2004; Joudrey & Gough, 2003; Joudrey, Mckay & Gough, 2004; Tracy et al., 2003). Similar research was also conducted with physicians and medical students, pharmacists and dieticians.

Though it could be hypothesized that the reason people use complementary therapies is because of their dissatisfaction with conventional medicine, studies show that this isn't always the case. Astin (1998) conducted a study that investigated possible predictors of the use of these therapies and found that only 5% of those studied were using them alone. Eisenberg (1998) found that one in three individuals saw a medical doctor for a principal condition and also used complementary therapies. Hence, it is seen that the majority of people are using these therapies in combination with conventional therapy (Thorne, Paterson, Russell, & Schultz, 2002).

2.2 Complementary Therapies in the psychological field

In the field of psychology, this statistic could suggest that clients are seeking both conventional psychotherapy as well as the use of a complementary therapy (White, 2000). Always keeping in mind the research questions, focusing on the relationship between psychotherapy and complementary therapies, I endeavoured to research complementary

therapies also in the psychological field. While in research the two professions and disciplines come together, especially on issues like anxiety, some researchers recommended further research to establish more clarity and additional knowledge.

Berger (2011), who focuses in her clinical work on trauma and women's issues while exploring, through research, the combination of complementary and alternative therapies with mental health counselling in the U.S., says that "there are a few studies directly linking the helping professions in psychology and the complementary therapies but currently the number is small and none have examined the relationship between counselling and complementary therapies specifically".

Some studies also referred to by Berger (2011), have, for example, looked at the use of acupuncture as an adjunctive treatment for substance abuse (Brumbaugh, 1993). She says that "there are a variety of reasons why substance-abuse therapists have explored complementary therapies but one important reason is treatment resistance with the clients" (Berger, 2011). This area, if further explored, could add more weight to the continued research looking at the connection between the two professions and disciplines. She adds that, thus far, the therapy field has not yet explored this issue in a generalized sense (ibid.)

One study by Collinge, Wentworth, and Sabo (2005) examined the combination of psychotherapy and energy therapies on such disorders as Post-Traumatic Stress Disorder (PTSD) and anxiety. Berger (2001) says "they used a small mixed methods design and found that both types of treatment were favourable for the clients in search of healing".

Bassman and Uellendahl (2003) surveyed 1000 members of the American Psychological Association (APA). From the collected data, there was a wide variation in the knowledge of complementary therapies; more than half wanting to know more about them; and a good percentage expressing concern on confusion of ethics and legality of incorporating alternative modalities. Among the findings was that "the percentage of respondents claiming expert or good knowledge in specific healing arts ranged from 10.0% for bodywork modalities to 59.8% for nutritional supplements" (p. 267). Only a few of the psychologists reported direct use of specific complementary practices. Further, they were more likely to recommend various modalities than to refer (Bassman & Uellendahl, 2013).

Lees (2011) says that by engaging with complementary methods, counsellors and psychotherapists can bring a holistic perspective to psychological (and physical) problems and build up 'political energy'. He adds that therapeutic effectiveness will be considerably enhanced by collaboration between counsellors, psychotherapists and other healthcare professionals. In his own words, "embracing medical systems is not paradoxical and does not compromise the principles of therapy, but enhances them" (Lees, 2011).

2.3 Why do clients seek both professions and disciplines?

Interestingly, there seem to be no studies against the collaboration between the psychotherapists and the complementary therapists' respective professions and disciplines. Meanwhile, when looking closer to the aforementioned 'holistic perspective', research shows that clients of complementary therapies appreciate that their therapists spend more time with them (Evenden, 2008). Research also shows that one of the reasons for clients seeking complementary therapies is the rejection of the biomedical model, seeing it mechanical and

reductionist (Frohock, 2002; Hyland et al., 2003; O'Callaghan & Jordan, 2003). Instead, they believe a holistic approach, however unconventional, is natural and therefore better and safer than a biomedical approach (Frohock, 2002; O'Callaghan & Jordan, 2003).

Evenden (2008) states that psychotherapy clients who seek complementary therapies may also feel that their interactions with their psychotherapist address this 'holistic' approach, with a more personal rapport than that offered through the biomedical model. In psychotherapy, this is more likely to be called the 'therapeutic relationship', central to a lot of psychotherapeutic research (Flaskas, 1997).

Starting from the complementary therapies, research carried out by Astin (1998) in the US reveals why people seek these therapies. Astin (1998) found that one of the most popular predictors of complementary therapies' use was philosophical congruence which he defined as the compatibility of the therapies with their values, worldview, spiritual/religious philosophy, or beliefs regarding the nature or meaning of health and illness. People who hold this philosophical orientation may be attracted to alternative forms of healthcare because they see in these therapeutic systems a greater acknowledgment of the role of non-physical (mind/spirit) factors in creating health and in illness. Another explanation (which would reverse the direction of causation) is that people who have been involved with complementary therapies have had their belief systems influenced by these therapeutic modalities and the philosophies underlying them (Astin, 1998).

A second significant predictor of the use of complementary therapies according to Astin (1998) was when someone had a transformational experience that made him view the world differently. This lends partial support to the hypothesis that involvement with complementary

therapies may be reflective of shifting cultural paradigms regarding beliefs about the nature of life, spirituality, and the world in general. As suggested by Charlton (1993), a subset of individuals may be attracted to these non-traditional therapies because they find in them an acknowledgment of the importance of treating illness within a larger context of spirituality and life meaning.

Thirdly, there are those individuals who categorized themselves as "cultural creatives". These are identifiable by the following values, commitment to environmentalism, commitment to feminism, involvement with esoteric forms of spirituality and personal growth psychology, self-actualization, self-expression and love of the foreign and exotic. They were significantly more likely to use complementary therapies, 55% vs 35% (Astin, 1998). This suggests that the growing interest in complementary practices may not simply represent a shift in individual beliefs about the nature of health and illness, but is rather a phenomenon that is transmitted through and influenced by the culture, in line with Gergen's (1985) approach in the social construction theory which sees ideas, concepts and memories arising from social interchange and mediated through language. Social constructionists believe that all knowledge and beliefs evolve in the space between people, in the realm of the 'common world' or the 'common dance' (Gergen, 1985).

Evenden (2008) says that "this cultural group tends to be at the leading edge of cultural change and innovation and thus seen to be more inclined to use alternative healthcare. One could hypothesise that this same group of individuals would choose psychotherapy for similar reasons that they seek complementary therapy. This group may be open to using talk psychotherapy given that they are characterized as being involved with forms of personal growth psychology and interest in self-actualization. This group may also choose to address

psychological problems with talk psychotherapy as opposed to taking psychotropic medication, because it is more in line with their holistic philosophy of health".

Turning to psychotherapy research, people seek to solve their problems and change for the better as shown through research conducted in Sweden, in the UK and in the US. In a study concerning remission from mild depression by Svanborg, Baarnhielm, Wistedt, and Lutzen (2008), former clients explained that they had obtained the desired change through acquiring tools to handle life, understanding their illness, facilitating a new way of approaching their particular problems, and through enhancing flexibility of thinking.

When interviewing people about change processes in general and comparing the answers to theoretical constructs about change, Higginson and Mansell (2008) reported hopelessness and issues of control; the change process; new self vs old self; and putting their problem into perspective as the main emerging themes. The person's determination to get better, the establishing of a degree of self-control, to be accepted as, and to accept oneself, as a normal person who exists beyond the mental health problem, having one's rights respected and returning to a meaningful social role through work and/or positive relationships outside of the formal mental health system; were the important themes reported in an international study of recovery among service users with serious mental illnesses conducted by Davidson et al. (2005).

Carey et al. (2007), when interviewing clients at the end of the therapy process to examine the foregoing change process, found that change occurred through the domains of feelings, thoughts and actions, and that the themes of motivation, aspects of self, tools, learning, therapeutic interaction, and relief through talking were all central. Other studies focus on

clients using both therapies simultaneously, showing that engaging in both therapies at the same time is not uncommon and there are specific reasons for people's decisions to do this. It seems that openness to therapy is accompanied by openness to different treatment options. One of these studies was conducted in the U.S. by Kessler, Soukup, Davis, Foster, Wilkey, Van Rompay et al. (2001), revealing that over half of clients engaged in psychotherapy are also using some complementary therapy modality. They found, for example, that 56.7% of a sample with anxiety disorder and 53.6% of a sample with depression had used complementary treatments in the previous year. Out of those engaged in conventional treatment for their mental health problem, 65.9% of the sample with anxiety and 66.7% of the sample with depression were also using complementary therapies. Related research by Elkins et al. (2005) reported that 64% of the surveyed psychotherapy clients were engaged in complementary therapies. Similarly, Kessler et al. (2001) conclude that more than 65% of clients who were in conventional psychotherapy treatment were found to be also engaged in complementary therapies.

While research addressing the efficacy and the benefits of psychotherapy and complementary therapies used simultaneously is lacking, a few studies managed to address why mental health clients seek complementary therapies. The reasons include improving psychological well-being (Targ, 2000), having a sense of control over treatment and health (Collinge et al., 2005; Hyland et al., 2003), and wanting to address emotional and spiritual needs (Astin, 1998). These motivators are similar to those found in the Astin's (1998) study mentioned above.

These findings suggest that psychotherapy clients who are seeking complementary therapies are doing so because they wish to have a more holistic, natural form of treatment, which includes addressing their psychological, physical and spiritual needs, and also be themselves

more involved in their healing process. It could also be assumed that psychotherapy clients seeking complementary therapy desire to focus on prevention instead of illness. These factors are important when considering their experience of their simultaneous use of the two respective therapies.

Collinge et al. (2005) led a study that integrated complementary therapies in a community mental health setting. The qualitative research findings as to what led the clients to participate in the complementary treatment were both psycho-emotional and somatic-related. The psycho-emotional reasons were a desire for peace and relaxation, easing anxiety and depression, and reconnecting with feelings whether of sadness, enjoyment or sense of self. The somatic-related reasons for participating in complementary therapy were identified to be the reconnection with a physical sense of the body such as liking the body, experiencing non-hurtful touch and regaining body control (Vanderbilt, 2006).

2.4 Complementary therapies and family therapy

Becvar et al. (1998) explore the implications of complementary therapies for family therapy. Family therapy, conceptualised from a systems perspective, builds on many of the same assumptions as those fundamental to complementary therapies. For example, "the two realms share acceptance of the interdependence of people and systems at all levels, a belief in non-linear and recursive relationships, a holistic approach, and awareness of our inevitable subjectivity. Considering the client's context, acknowledging the uniqueness of each client and his system, and nurturing change are surely common factors of both therapies, not to mention the systemic stance of theoretical relativity, acknowledging possible utility in all belief systems, depending on the context" (Becvar et al., 2008). Meyerstein (2000) refers to

the art of collaboration as a complex endeavour which requires a systemic understanding of the existing differences in culture, language, theoretical model, training, confidentiality, use of time, and working style (McDaniel et al., 1990).

In one of her articles for the American Counselling Association, Berger (2011) refers to a study by Caldwell, Winek, and Becvar (2006) and Becvar, Caldwell, and Winek (2006), who explored the relationship of complementary therapies to family therapy, which in the U.S. is generally referred to as Marriage and Family Therapy (MFT). This was done both through a national survey and through qualitative interviews and it was found that MFT therapists are indeed encountering clients using complementary therapies. The research revealed, however, that the MFTs lacked education about the various complementary therapies and determined that there was a need for further education for both practitioners and clients so that these therapies can be properly assessed for safety and efficacy (Berger, 2011).

Interestingly, Caldwell et al. (2006) apply the same categories of complementary therapies as categorised above to explore through a national survey the relationship between family therapies and complementary therapy approaches. The findings include a good percentage of respondents, amounting to 71%, who are family therapists in this study, revealing specific knowledge of complementary therapy practices. 88.1% of the respondents recommending such practices to their clients. The study shows that only 45.6% reported a relationship with a complementary therapist to whom they make referrals. Indicating types of problems for which they would refer clients to complementary therapies, these family therapists designated 11 categories, including stress and anxiety, depression, eating disorders, trauma and other psychological and emotional issues. A third of the family therapists participating in this study

said they received referrals from complementary therapists for problems varying from relational issues to depression, stress and anxiety (Caldwell et al., 2006).

2.5 The Mind-Body Connection: Bringing together both professions and disciplines

Other studies focus on the healing power of the expressive touch which shows empathy and transmits healing. Nathan (1999) reminds us that in our early days of life, various forms of touch, in the form of rocking, holding, cuddling and unsophisticated massage, are seen as healing acts. Nathan (1999), who is an osteopath himself, posits that, "it is because touch is essentially intimate, any type of intentional touching, like in massage therapies, will be emotionally significant in some way. The act of humans touching each other in physical and emotional distressful times has likely existed for quite a long time". Touch is the original archetype of empathy (Nathan, 1999). "Touch, in the form of massage and other touch therapies, can have empathetic qualities similar to that of the empathy that is expressed in psychotherapy".

Much of the literature on the healing power of touch originates from conducted studies in nursing, particularly the effects and use of touch in intensive care settings (Ingham, 1989). Research has shown that the anxiety and fear of a patient are often reduced by the nurse's touch (Nathan, 1999; Weiss, 1990). The touch by such professionals often promotes a feeling of being with and sharing rather than doing unto, which is usually what patients experience when receiving medical attention. The act of being-with, as experienced by touch, could possibly be classified as a form of healing (Nathan, 1999). Even though the modern medical world presents healing in the form of medicine prescription and surgery, one could ask if the touch in complementary therapies could be effective as the powerful medicine. Furthermore,

in line with the research questions and for the purpose of this study, the question could be altered to ask how the power of touch, or in a wider context – the focus on the body in complementary therapies alongside of the use of talk in psychotherapy, are a more effective way to treat individuals with mental illness, for example.

Collinge et al. (2005) discuss the efficacy of touch therapies with people who suffered trauma. For example, increasing numbers of survivors of abuse and trauma who have sought various touch therapies to help them reconnect with and reclaim their bodies (Benjamin & Sohnen-Moe, 2004). In fact, many psychologists and psychiatrists are referring their clients for such complementary therapies (Benjamin & Sohnen-Moe, 2004). This supports the notion that the combination of bodywork and psychotherapy could potentially be more effective than psychotherapy alone.

Sloat (as cited in Benjamin & Sohnen-Moe, 2004), says that bodywork for abuse survivors can be a very powerful adjunct to psychotherapy. She continues that, through the bodywork, clients can reconnect and move towards wholeness by using the body as a vehicle. It is also believed that bodywork can help clients develop a friendly and compassionate relationship with their own bodies, often seen as dirty or disgusting, especially post-trauma of physical or sexual abuse. Moreover, working with an empathic practitioner can help a client rebuild a sense of trust and experience a caring and healthy relationship with another person (Benjamin & Sohnen-Moe, 2004). The use of bodywork and touch with clients who have experienced trauma can be possibly efficacious and positive in their healing process.

Another area of research combines work in body psychotherapy, neuroscience and psychobiology in discussing the benefit of psychotherapy and complementary therapies,

addressing both psychological and somatic aspects of a person's being. The premise is that psychological issues can have both a physiological and a psychological component (Evenden, 2008). In neuroscience, the bulk of research that has addressed the idea of emotions having both a psychological and physiological aspect is found in the area of trauma.

Applying his knowledge of psychobiology to understanding the interaction of the body and mind in relationship to trauma, Van der Kolk (1994) in *"The Body Keeps the Score"*, reviews the existing research about the neurobiological underpinnings of traumatic reactions. He describes how trauma disrupts the stress-hormone system, plays havoc with the entire nervous system, and holds people from processing and integrating trauma memories into conscious mental frameworks. Because of these complex physiological processes, in effect, traumatic memories may stay stuck in the brain's nether regions: nonverbal, non-conscious, sub cortical regions (amygdale, thalamus, hippocampus, hypothalamus and brain stem) where they're not accessible to the frontal lobes, which are the understanding, thinking, and reasoning parts of the brain (Van der Kolk, 1994). He suggests that it is the body, not the mind, which controls how one responds to trauma.

Clients with post-traumatic stress disorder experience intense emotions without being able to name their feelings (Van der Volk, 1998). Adding that their bodies are aroused and that fragments of memories may be activated, he says that they are unable to form a clear mental construct of what they are experiencing (p. SI 05). Traumatic experiences involve the whole person's emotions and feelings, identified as the mind, body and spirit, adding that it is believed that traumatic experience is evidenced at the biochemical/neuromuscular levels and that treatment must integrate cognitive-based narrative therapy (psychotherapy) with somatic body memory treatment" (Van der Volk, 1994, p. 254).

2.6 A local perspective

Within a local perspective, such literature is scarce on all fronts, whether it is complementary therapy, psychotherapy as well as on the collaboration of both. From the field of complementary therapy, if I were to hypothesise, I would say that the most commonly spoken term in this field in Malta is 'massage therapy', which has been increasing globally in popularity as part of the complementary and alternative medical therapy movement (Moyer, Rounds & Hannum, 2004). Interestingly, in 1993, massage therapy ranked fourth among the most frequently used forms of such therapies, after chiropractics (first), acupuncture (second), and hypnosis (third) (Eisenberg et al., 1993).

That said, in Malta I would say that massage therapy is not generally popular for the right reasons but for "its perceived association with sex work activity rather than healthcare" (Fournier & Reeves, 2012). It is enough to conduct a quick internet search with the keywords 'massage therapy Malta news', and the first links you get confirm this, along with headlines like "Regulate massage parlours acting as brothels"; "Massages with 'full extras' still being advertised online"; "Man who went for Chinese massage in Buġibba gets more than he bargained for"; "Raising the bar for the masseur profession". Other complementary therapies offered in Malta are aromatherapy, reflexology, acupuncture, osteopathy, homeopathy, deep tissue massage, reiki and others.

In the field of psychotherapy in Malta, more research seems to be encouraged on how, when, why and to whom people turn when it comes to such therapies. My hypothesis is that people still do not understand clearly the distinction between a psychologist, a psychotherapist and a psychiatrist, not to mention the confusion which happens to characterise the whole scenario

through counsellors calling themselves therapists and psychologists advertising their services as therapy services.

Chapter 3: Methodology

The aim of this chapter is to set out the methodological approach undertaken to address the research questions focusing on the relationship between the respective professions and disciplines of psychotherapists and complementary therapists in Malta. This chapter will present the choice of sample, the adopted approach and research tool, and the method used for data collection along with the process of data analysis through discourse analysis adopting a social constructionist framework. It will also include the researcher's self-reflexivity and the ethical considerations.

3.1 Choice of sample

Keeping in mind this is a systemic study, I want to look closer at the relational aspects by exploring the potential collaboration between both professions and also the different ideologies behind the respective disciplines and the involved professionals. To do this, I intend to engage a mix of psychotherapists and complementary therapists for a focus group. I have adopted a purposive sampling technique, which is widely used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources (Patton, 2002).

This involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest (Cresswell & Plano Clark, 2011). It involves selection ''based on a specific purpose rather than randomly'' (Tashakkori & Teddlie, 2003a, p. 713). Besides inviting participants who are qualified professionals in the respective professions and disciplines under study, I aimed at having

diversity, varying from age and gender diversity, to completing studies in different institutions in Malta and also abroad, to different areas of specialisation.

I have included systemic psychotherapists working in different contexts like addiction, mental health and also in private practise. All of them are family therapists. One of them has also studied Gestalt psychotherapy. From complementary therapy, I included a massage therapist and reiki master, a reflexologist and aroma therapist, an osteopath, a health coach who is also a yoga and meditation practitioner with qualifications in nutrition as well, an acupuncturist and a homeopath.

3.2 Qualitative approach: A focus group

Driven by the research questions, I could not avoid taking a qualitative approach. I have done this through the use of a focus group as my research tool. As I was focusing on two professions, I thought that it would be good to benefit from this economical, fast and efficient method for obtaining data from multiple participants (Krueger & Casey, 2000). I also thought of increasing the overall number of participants through a qualitative study (Krueger, 2000). Other characteristics of focus groups which I considered before deciding to choose this research tool were the group interview environment, which is socially oriented (Krueger, 2000) and the sense of belonging to the group, which Peters (1993) says can increase the participants' sense of cohesiveness and help them feel safe to share information (Vaughn, Schumm, & Sinagub, 1996).

In addition, the interactions that occur among the participants can yield important data (Morgan, 1988), can create the possibility for more spontaneous responses (Butler, 1996) and

can provide a setting where the participants can discuss personal experiences and problems, and provide possible solutions (Duggleby, 2005). For the purpose of this study at a Masters Level of training, I opted for an individual, two-hour focus group which consisted of nine participants. My choice was guided by research which clearly says that well-designed focus groups usually last between one and two hours (Morgan, 1997; Vaughn et al., 1996) and consist of between six and twelve participants (Baumgartner, Strong, & Hensley, 2002; Bernard, 1995; Johnson & Christensen, 2004; Krueger, 1988, 1994, 2000; Langford, Schoenfeld, & Izzo, 2002; Morgan, 1997; Onwuegbuzie, Jiao, & Bostick, 2004).

The rationale for this range of focus group size stems from the goal that focus groups should include enough participants to yield diversity in the information provided, yet they should not include too many participants because large groups can create an environment where participants do not feel comfortable sharing their thoughts, opinions, beliefs, and experiences.

3.3 Organisation and data collection

Having invited all of the participants a month ahead of the focus group, knowing that they are very busy people, I acknowledged that it was not an easy task to make all of them agree on a particular day and time. Thus, I kept in mind what Morgan (1997) suggested when he spoke of over-recruiting by at least 20% of the total number of participants required. In fact, I invited twelve participants, six from each profession and ended up having nine of them present. Unfortunately a systemic psychotherapist who had trained in the UK, refused the invitation immediately because of other duties which he had already scheduled on the targeted day, and another two accepting the invitation have declined their participation on the

eve of the focus group because of personal reasons. The six complementary therapists I invited were all present.

All of the invited participants were initially contacted by phone and asked if they would accept to volunteer to be part of this study. Upon their registered interest on the phone, they were emailed the information sheet (APPENDIX A) explaining the research project, which was accompanied by the consent form (APPENDIX B) which they were asked to sign, giving me permission to record the session.

3.4 Data analysis

The adopted source for the focus group data analysis in this research, was the transcript-based analysis, which is the most rigorous and time-intensive mode of analysing data. After careful transcription, the lines were coded and the identities of the participants were removed to ensure that confidentiality is respected and replaced with fictitious names. This was followed by a thorough process of reading and re-reading the text and coding in the right hand margin the emergent themes, reflecting the content of data collected from the focus group participants. An example of this process is reproduced in APPENDIX D. As explained in the next section, discourse analysis was used to analyse this content, viewed through a social constructionist lens.

3.5 Discourse Analysis: Adopting a social constructionist framework

Keeping in mind the research questions, I was all the time aware of the relationship between the two professions: complementary therapies and psychotherapies, including their

ideologies. Inspired by Cecchin, Lane & Ray (1994), upon approaching this systemic study I was curious about of the interplay of beliefs and assumptions of both clients and therapists in the respective disciplines. Furthermore, I was interested in how the respective therapists become 'observers to their own beliefs' (Fredman, 1997) by identifying the beliefs and stories that they draw from their different personal and professional contexts, such as family, culture, gender, religion and work. I was also curious about how they generated a repertoire or ecology of ideas, beliefs and theories in relation to clients' presenting issues and problems. McNamee (2005) notes that Cecchin's (1987) 'curiosity' approach requires the therapists to hold not only to their own perspectives but also to the perspective of others. This research was inspired from a social constructionist framework, with concentration being dedicated to investigating the social influences, the social aspects of all that is psychological (Owen, 1995).

Gergen (1985) defines social constructionism as a perspective which believes that a great deal of human life exists as it does due to social and interpersonal influence. Owen (1995) says that social constructionism regards individuals as integral with cultural, political and historical evolution, in specific times and places, and so re-situates psychological processes cross-culturally, in social and temporal contexts. Apart from the inherited and developmental aspects of humanity, social constructionism hypothesizes that all other aspects of humanity are created, maintained and destroyed in our interactions with others through time. The social practices of all life begin, are recreated in the present and eventually end (Owen, 1995).

Owen (1995) adds that, for therapy, this view emphasizes the importance of the acquisition, creation and change of emotional behaviour, therapeutic ability and ways of interpreting things and people. "As the genetic material of each race and region is different, as well as the

cultural practice, then one can assert from the start that there is no universal truth". In postmodernism, postmodernists argue that there is no one truth but multiple truths, no one reality but multiple realities. He concludes that "what social constructionism shows to be important are the ways in which socialisation and enculturation amongst the people one has known, plus the current influence of those whom one knows now, are the most active in shaping his/her mutual existence with others" (Owen, 1995)

Burck (2005) says that discourse analysis is located in a social constructionist paradigm. The focus of discourse analysis fits well with systemic psychotherapists' interest in language and dominant and subjugated meanings (White & Epston, 1990), and offers a framework for the deconstruction of meanings. Discourse analysis involves a close scrutiny of language examining ways in which certain themes are being discussed. Discourse analysts ask questions about language such as: What actions does this piece of talk perform? What accounts are individuals trying to construct in interaction with each other? How do these accounts change as contexts change? (Wetherell & White, 1992). Indeed, these are questions close to heart for systemic practitioners.

Discourse analysis offers a way to scrutinize the 'orderly ways of talking' with which individuals account for and make sense of themselves and their social worlds (Shotter, 1993). Burck (2005) also says that a basic tenet of this kind of analysis is that people use language to construct versions of the social world; that language is not a neutral and transparent medium through which people are able to express themselves but is constitutive. She elaborates that discourse analysts seek to identify the discourses and interpretive repertoires that individuals draw on to make sense of their world, and to examine their consequences and limitations. Discourse is here regarded as a set of meanings, metaphors, representations, images and

stories (Burr, 1995), and as an institutionalized use of language (Davies & Harre´, 1997) which produces particular versions of events and the social world.

Through this lens, I will review the emerging data from this research in terms of the respective therapists' reality constructs of the respective disciplines which, as explained above, are expressed through language in the process of interaction, according to the culture and the social and interpersonal influences. Such creation of knowledge between groups such as society gains ground as a 'discourse'. The role of the 'objective expert' is lost, in that as Taylor (2001) comments that researchers "offer an interpretation or version which is inevitably partial". The researcher must consider himself or herself as part of the research process and reflect on his or her impact within it.

Discourse analysis research pursues this thinking. It is concerned with how people use language, what is accomplished as a result of such use, as well as which resources they have drawn from in shaping their conversation. (Potter & Wetherell, 1995). It is interested in discourse as a thing in itself; In how it has been constructed and how it is tied to other meanings in society, as well as the function it serves. In my study, I want to observe the way the participants use language to express their ideas on problems and change, for example. I also want to observe the understanding of this in relation to other meanings by people in society.

This mode of analysis seeks to outline different discursive practices through which social phenomena such as gender are constructed (Couture & Sutherland, 2004). This can be linked to Foucault's understanding that power and knowledge are indissolubly joined, such that one never has either one without the other (Kelly, n.d.). As Kogan (1998) explains, "meaning

making… is…embedded in a social context that promotes specific meanings and hinders others". Thus some discourses become 'dominant' ones that are generally accepted, whilst others are 'sidelined' or 'subjugated'. Outlining these different discourses helps widen our understanding of social phenomena.

Analysing the transcripts by using discourse analysis over other methods was because I wanted to investigate discourses, and because as a research method it is very much in line with the contemporary emphasis on language and meaning making in therapy. Avdi (2005) states that within a social constructionist perspective, psychotherapy is viewed as "the creative generation of new meanings in the context of collaborative discourse". Moreover, discourse analysis has a long history of being used in healthcare settings (Heritage & Maynard 2006; Drew & Heritage, 1992). Theoretically, it prioritises social context as a site for creating and interpreting meaning (Roberts & Sarangi, 2005; Gee, 2011) and assumes that language does not simply reflect inner knowledge, attitudes, and beliefs, but rather through social interaction, participants' language use negotiates different types of meaning (Hodges, Kuper & Reeves, 2008; Shaw & Bailey, 2009). Methodologically, discourse analysis shows how participants manage multiple meanings in context. Finally, it recognizes that some meanings may be more explicit than others, depending on contextual features of the social situation (Gee, 2011).

3.6 A systemic perspective to the research

Simon (2014) says that research methodologies are products of time, place and culture. They "are not items on a shelf which one takes down and uses as ready-made products". She explains that it is very much useful and in keeping with a systemic approach to think about

research as a process of mutual shaping in which researchers and co-researchers are changed by each other and by the activities; in turn, the research methods and activities also evolve through the influence of researchers and co-researchers.

This sense of openness influenced my approach in this research, inspiring the use of systemic questions in the focus group with professionals from psychotherapy and complementary therapies. "Systemic questions create opportunities for new telling of old stories, for imagining alternative futures and for reconfigurations in relationships between people, their narratives and actions" (Simon, 2014). Exploring the relationship between psychotherapists and complementary therapists and their ideas of what constitutes a problem and on what brings about change, conducting the focus group through the use of these questions, aimed at stimulating the participants' thinking especially about the relational activities in the professional relationship (Anderson & Gerhart, 2007; Flaskas, 2002; Flaskas et al, 2004). Eliciting the data and investigating discourses in a social constructionist framework aimed at focusing on how the participants shape meanings between themselves in responsive dialogue as all emerging knowledge is fluid, contextualised and created by people in relationship (Cunliffe, 2008).

As a researcher, while declaring my personal interest, I also wanted to take a not-knowing approach (Anderson & Goolishian, 1992), being curious through the asked questions (APPENDIX C), opening up space for participation aiming at making way for meaningfulness arising out of the random (Burnham, 1993). Maintaining systemic thinking throughout, I wanted to look at the emerging data as different forms of knowledge rather than as one form of knowledge better than the other one. I also wanted to self-reflexively be part of the system, a stance upon which I will further elaborate in the next section.

3.7 The researcher's self-reflexivity

Berg & Smith (1988) speak of self-scrutiny as the intellectual and emotional factors that inevitably influence the researcher's involvement in the research process. In fact, both factors come together in my thematic choice of this piece of research. Choosing to explore the relationship and potential collaboration between psychotherapy and the complementary therapies in Malta was not by coincidence. As explained in my introduction to this research, through my relationship with my partner at a time when I was studying systemic psychotherapy, I learnt a lot about the value of complementary therapies. Along the years I have been a client of both therapies, experiencing their different methodologies, even though they might share conceptualisations of problems and change.

Reflecting on my biases and how they may have impacted the research process, I think that as a first, I was too focused on the way the two professions and disciplines could embark on a process of collaboration in Malta. In systemic practice, I recognise the impossibility of neutrality and objectivity. I accept that when, through my partner, I realise how professionals unfortunately work on their own, it hurts me, particularly because I am extremely in favour of inter-professional collaboration.

I own my prejudices and I acknowledge that, for example, I am not much in agreement with some of the medical professionals who prescribe medicine upon assessing the symptoms while seeming to rule out the understanding of the language of the patient's body and the holistic factors which may be leading the patient to feel sick. While I feel it is important to have the medical professionals' perspective, I believe it should also go parallel with educating the patient on how the physical, emotional and intellectual aspects are connected.

This then translates in learning how one listens to his/her body, how to eat healthy and exercise, how to deal with thoughts and emotions and more. Having said all this, I think that it made me focus more on how I want things to change.

The fact that I have been studying systemic psychotherapy could have been another source of personal bias in this research, potentially being reflected in the interview guide I prepared. My training in self-reflexivity could have led me to prepare questions which may have been too rational for complementary therapists who lack that kind of training. This could have placed the psychotherapists in an advantageous situation when it came to the answering of such questions and to the eventual group discussion.

At times, I was aware that my curiosities were overwhelming, leaving me with a dilemma as to what to prioritise and what to include in my study. One particular area, for example, which I admit I want to learn more about, is that of embodiment and neuroscience. One significant moment I experienced during this exciting research process was when I came across 'The Body Keeps the Score' by psychiatrist, educator and researcher Bessel van der Kolk (1994). One of his arguments on trauma struck me in particular. He says that the impact of trauma is in the somato-sensory self, and it aroused my curiosity further by looking into the relationship and the connection between the mind, the body and also the emotions. Consequently, my internal dialogue was enriched by how talk therapies work, by how complementary therapies work and by how people seek various therapies to sort out their issues. In hindsight, going into more depth in this area would have possibly taken the participants' contribution and the research to a higher level.

The participants' input during the process of data collection, during the focus group interview, was very significant for my internal dialogue. It reinforced my thinking about the need for more awareness in both professions and disciplines and amongst the respective therapists, the necessity for more educational efforts from early school days, and the furthering of mutual collaboration between the professionals involved.

My role as a moderator during the focus group interview made me focus more on what was being said and unsaid, through listening and observing. In a circular manner, I also believe to have managed to take the participants to a higher level of thinking. At times, their silence or hesitation was interpreted in this sense. In particular instances some of them even asked me to paraphrase the question. I also believe that I was an eye opener for all of them to reflect on their own ideas and beliefs, possibly also a motivating force aiming at furthering research in this area. Their request for me to organise more similar events in the future filled me with enthusiasm. I interpreted that as a sign of a living process, a flame which we all needed to keep burning.

I would like this process to make me probe deeper and ask questions which are not limited to the respective professions and to the complementary therapists and the psychotherapists' ideologies, but also around the clients benefitting from the respective disciplines, with particular attention to the Maltese context. I would like to explore further the clients' conceptualisation of 'health' and 'well-being' through these therapies, and how the received help is related to questions of identity, self and subjectivity together with emotions. I would also like to influence the public discourse, the powerful sense of rigidity pervading the medical model in the use of language, and the dominant narrative around these subjects in the

Maltese context. I believe that both my experience as a former teacher and as a media person can help me materialise this dream.

Remaining open for this process of change, I intend to contribute towards trying to change the local system. Undertaking this research has been a first step. I intend to continue with my research when graduating and starting to practise as a fully qualified psychotherapist myself. I am also convinced that this research can motivate the discussion around the subject of psychotherapy and complementary therapies, can lead professionals to engage in fruitful discussion, and can push forward innovative ideas which might end up in the public fora and on the political agenda, in the hope that our health system in becomes a truly holistic one.

3.8 Ethical considerations

A research proposal was submitted to the Ethics Board at IFT-Malta and ethical approval was granted by the supervisor prior to the commencement of this research. In conducting any type of research, a researcher must at all time be aware of the impact which the research will have on participants and on society as a whole and must therefore act accordingly. Kumar (2005) acknowledges that it is unethical to accumulate information without the knowledge of participants, and their expressed willingness and informed consent.

In view of this, as the researcher, I made it clear to all participants that their participation was on a voluntary basis and that they were free to withdraw from the study at any time. I explained the aims of this research, the advantages of their participation and the focus group logistics, together with how their expressed information was intended to be processed. This included an explanation that there were no right or wrong answers to the focus group

questions; that the research project was aimed to make way for as many different viewpoints as possible and that it was hoped that everyone expressed one's view freely.

Participants were given a month's notice prior to the interview. All participants signed the consent form, ensuring them confidentiality and anonymity throughout the whole process.

Chapter 4: Findings

4.1 Introduction

The relationship between the psychotherapists and the complementary therapists, their professions and disciplines in Malta was explored through the analysis of the collected data in the form of discourse. The findings, being presented under the five emerging main themes in the table below, illustrate the relationship of the discourses, as well as the interconnection among various elements that emerged during the research.

• Juggling power and professional status
• Establishing and maintaining professional territory
• The process of change
• The medical profession: Omnipotent and Omnipresent
• Professional collaboration: In the realm of possibility

Some of the themes comprise emergent sub-themes which are reported in detail, given their importance of contextualising the participants' experience. All of the main themes are interconnected to, and interrelated with, the research questions. The themes relate to each other through the language of dichotomies, especially when therapists in the respective professions refer to the medical profession, empowering it at the same time. Interestingly, however, the same therapists use discourse of collaboration, despite creating a sense of ambivalence through their holding on to their professional territories. Another relational

aspect of these themes lies in the way these therapists look at clients' presenting problems and in the way they conceptualise change.

Before presenting the findings of this study, in the table below I will present this information: the focus group participants' names (fictitious names are used to ensure confidentiality), the therapy modality they practise, and the amount of years they have been practising as fully qualified professionals.

Name	**Age bracket**	**Therapy modality**	**How long they have been practising**
Edmond	25-34yrs	Systemic Psychotherapy	6 months
Sophie	35-44yrs	Systemic Psychotherapy	10 months
Jane	35-44yrs	Systemic Psychotherapy, Gestalt Psychotherapy	19yrs
Maria	25-34yrs	Massage therapist, Reiki Master	10yrs
Anabel	45-54yrs	Reflexologist, Aroma therapist	15yrs
Peter	25-34yrs	Osteopath	7yrs
Amy	25-34yrs	Health Coach, Yoga/ meditation practitioner	3yrs
Elena	45-54yrs	Homeopath	11yrs
Paul	55-64yrs	Acupuncturist	17yrs

In my findings, for ease of reference, each participant's fictitious name will be followed by (CT) to indicate he/she is a complementary therapist or (PT) to indicate the participant is a psychotherapist.

4.2 Juggling power and professional status

Striving to assert their own expertise and struggling for own professional status in society was often highlighted in the participants' discourse during the focus group. The majority of

participants, hailing from both psychotherapy and complementary therapy, seemed to be in a struggle to establish their professional status in the Maltese context. In different societies and fields of work, just to give two relevant examples, individuals are raised in a hierarchy and learnt that there are pecking orders. Since one's childhood, the following questions have always reflected the pecking order: Who holds the reins of power at home and in what way? How do other people stack up? What human circumstances give people power in the family? How do family members compete for resources? Did I ever try to be on top? Did I try to be favoured by whoever was on top? Did I retreat to the last of the pecking order so as not to feel responsible? In this study, the majority of psychotherapists and complementary therapists speak of professional 'acknowledgment', 'the need to be recognised' and 'acknowledged'.

Sophie (PT), who works as a family therapist in mental health, declares that her designation is that of a psychology assistant. She says:

> *Jien għalkemm naħdem mal-gvern ma ngħaddix bħala family therapist għalkemm nipprovdi s-servizz tal-family therapy. Jiena psychology assistant nissejjaħ jiġifieri lanqas by designated profession ħa ngħidu hekk. Għax s'issa ma jiġux impjegati. Jiġifieri bħalkom inħossni...(lines 366-369)*
>
> *Although I work for the government, my status isn't that of a family therapist even though I provide family therapy. I am called a 'psychology assistant', therefore not even recognised by my profession because for now, they are still not being recruited. I get your feeling... (lines 366-369)*

Using the word 'status' possibly shows her idea of hierarchy while the last three words could be confirming the feeling that was already felt and reflected in the first few minutes of the session through different discourse by complementary therapists who, through the said and the unsaid, seemed to be already positioning themselves as not socially acknowledged or

possibly not respected for their expertise. It looked quite clear from the beginning that there was some kind of antagonism within the professional community.

Interestingly, one complementary therapist uses a completely different discourse. Peter (CT) speaks about his profession as an osteopath and says that, in Malta, this profession is empowered by means of regulation from the council of professions, adding that:

> *...so we enjoy certain regulations and standards of practice. (line 90)*

This could be highlighting power. The use of the verb 'enjoy' may be showing an element of advantage over others who do not enjoy the same regulations and standards of practise. The use of 'enjoy' potentially translates to the desirability which everyone would want but not everyone has. At the same time, it could be further leading the other complementary therapists to feel less empowered due to the fact that their therapies are not regulated and professionally acknowledged alike. Moreover, when Peter (CT) speaks of osteopathy, he says that:

> *"...if you want to become a doctor in the US, he/she can choose whether to be an MD or a DO which is a doctor of osteopathy". (lines 114-116)*

Later on during the session, the same participant says that they work close to general practitioners (GPs):

> *"We draw and we have some referred by GPs and this is following my efforts to try to communicate also with GPs, some GPs actually ended up being our patients as well themselves..." (line 711-713).*

This discourse seemed to create a lot of discomfort for the other complementary therapists, evident through their non-verbals, and through eye contact amongst complementary therapists, sneering and a collective raise of eyebrows. At the same time, this discourse indicated that being a doctor somehow seemed to set a benchmark. It reveals as well that the majority of colleagues possibly had a wrong impression or maybe they were generalising too much when they seemed to be taking it for granted that all complementary therapists in Malta were not officially recognised and regulated. Thirdly, it shows that when one strives to 'communicate', to explain and promote his work, then the result will reflect a different scenario which constitutes a subjugated reality which is, so far, still very blurred to the majority of the complementary therapists. Jane (PT) attempts at balancing the unsaid discourse of this subjugated reality by saying:

> *"I think there are counsellors, whatever, even psychiatrists or medicals who are actually very open to these ideas but I think we need to find the way how to make this a more possible conversation." (lines 668-671)*

4.2.1 Feeling like lesser beings?

In this scenario, the complementary therapists seem to portray themselves as the underdogs, to the extent that some of them possibly feel like they are lesser beings, or even objects of 'ridicule'. Elena (CT) is very strong about this latter feeling, mentioning it four times:

> *"There are some doctors, even some specialists, who believe even in homeopathy, the rest I am afraid even ridicule and I find that very unjust because people need to know." (lines 355-357)*

> *"What's the problem is the attitude from the medical side. A lot of people benefit from these complementary medicines and yet when they go back to their*

doctors they are afraid to tell them because they are afraid of being ridiculed and sometimes they are." (lines 1065-1068)

"...what I don't understand is why doctors ridicule clients..." (lines 1087-1088)

"when there is someone who doesn't know, says 'I don't know', but others ridicule their patients when they tell them they have improved." (lines 1088-1090)

Such feelings seem like a shared sentiment amongst the complementary therapists and within their discourse of struggle in asserting their social status and their professional abilities, whilst seeing their efforts possibly hindered or undermined. Meanwhile, also easily noticeable during the interview, was the lack of reaction to such a strong sentiment from the psychotherapists' side.

Anabel (CT), speaking of her efforts to see complementary therapies become more respected and recognised in the health sector in Malta, refers to her proposal of creating a hospice for cancer patients. Anabel (CT) says:

"Why shouldn't we get there eventually? So hopefully am trying, am trying." (lines 261-262)

"...when you try to organise...unfortunately you wouldn't find help..." (lines 266-267)

Reinforcing the state of helplessness, Paul (CT) goes a step further and introduces the idea of 'opposition' which through the used discourse, I understand that the complementary therapists feel very strong about.

"And you'll find opposition..."(line 268)

Anabel (CT) approves and gives an example with one of her experiences.

> *"Yes, a lot. I mean...we were allowed to go to Boffa and SAMOC (Sir Anthony Mamo Oncology Centre)...and then normally the therapists are off on Monday. Well, not me. But they said No, because the doctor took your slot. I said we were supposed to have it all...so...eventually it's all about when they go and get the badge from Marsden and then that's it. Punto e basta." (lines 269-271)*

A sense of helplessness follows which likely reflects one's resignation. Anabel (CT) adds:

> *"Now, for patients who come with cancer, they come to my salon, I wouldn't charge them and that's it. I will still do my job. Cos for me is doing something good and you'll get 100 times back. And that's it." (lines 273-276)*

Maria flashes a ray of hope:

> *"Yes, We are the people who need to push this thing forward, it's a new concept ...it's my mission. And we hopefully change the face of healthcare." (line 277)*

4.2.2 Mirroring expertise in certainty or cautiousness

Discourse of power emerges also in one's profession. Acknowledging that complementary therapists possess expertise in their area of practice, it seemed that the complementary therapists in this group were possibly more certain of themselves, while psychotherapists, who also hold the relevant academic qualifications, seemed more tentative.

One particular instance when this appeared very clear was during an exchange between Edmond (PT) and Amy (CT). The context was the importance of professional collaboration

and how one decides to refer to other professionals. Edmond (PT) acknowledges 'limitations' and in one intervention he repeats the word three times. The following is just one example:

> *"I'm not just a therapist but I am also a human being so my story influences my practice and it also influences my limitations. As a therapist there is no...It's not possible for me to work with every kind of family or every couple." (lines 1042-1044)*

Edmond (PT) goes tentative, saying "maybe I don't know enough" and adds that:

> *"I am happy when I also hear you saying that there are limitations in this aspect of work and you refer to somebody else." (lines 1047-1048)*

As a reaction to this, Amy (CT) seemed to link it with expertise by saying:

> *"The more specialised you are the better you serve your clients and yourself..." (line 1052)*

These words, particularly the word 'specialised', are likely to relate to the complementary therapists' possible feeling of certainty. Amy's (CT) choice of words in the following text, which were expressed exactly before, creates further ambivalence.

> *"...You can't possibly give a client or a patient everything because they will come with all kinds of challenges and issues and problems and conditions. And when you collaborate the interest is in helping and healing that person; when you are greedy and 'you think: no, no, no, I don't want to share', you give out bad energy and patients and persons equally feel that and it's not a nice thing... But you just can't service the whole island. It's great that you are busy but you can't do the whole island on your own." (lines 1027-1036)*

At the same time that Amy (CT) is speaking in favour of collaboration, she seems to give the impression that if it were possible to "give everything" to a client and "service the whole island on your own"; she would do so, because "it's great that you are busy".

Discourse of reflexivity seemed more evident from the psychotherapists than from complementary therapists. Edmond (PT) repeats the word twice in one intervention.

> *"I would say there's a bit of lacking when it comes to reflexivity...I would say in my context I see a lot of lack of reflexivity...". (lines 1041-1046)*

Edmond (PT) warns that the more years of practice under one's belt, the more big-headed one could become.

> *"makes you lose sight of the connection with where you are and what your limitations are".*

At this point he speaks of the importance of supervision, the source of support for the psychotherapist. Amy (CT) agrees also with this, saying:

> *"The coach always needs to be coached and the therapist always needs to be (therapied)/laughs." (lines 1063-1064)*

4.3 Establishing and maintaining professional territory

Territory issues were evident during the focus group interview. Although the word 'territory' featured only two consecutive times by the same psychotherapist, a lot of words and phrases were intrinsically related to territory, expressed by the majority of therapists during the whole

interview, conveying a message of ‘us’ and ‘them’, and revealing also the sense of Malta as a small island, a face-to-face community with the Maltese people and their perceptions against a rich backdrop of history and culture.

A quotation from Jane (PT) which sums up a lot of what was being said by different participants, and which is very much in line with the research questions – for the simple reason that it deals with the collaboration between the respective professions and disciplines – ropes in the idea of Malta being a small country which might lead to some kind of insecurity. To this effect, a therapist might choose to protect his/her territory so that one doesn’t lose clients and secures his/her job. On the other hand, Jane (PT) says that the more secure and self-confident a therapist is, the more he/she collaborates with other professionals.

> *“What I’ve noticed is that the more secure and comfortable in their shoes practitioners are, the less the need for competition and the more possibility of collaboration and multi-professional work. I’ve observed that when people feel comfortable with who they are and what they do, they tend to refer more and they tend to work more as a team... whereas in our culture, you cannot generalise, but it can happen that if there is kind of, ‘I want to keep my territory’ and ‘I need to be on top of the pack’ and ‘I’m the best in what I do’ or ‘what I do is better than what you do’ – that might possibly reduce the possibility of multi-professional collaboration, so because we’re a small country and people might kind of prefer to hold to their territory.” (lines* 1017-1026)

Maria (CT) says she refers clients to psychotherapy, but she queries how psychotherapists can reciprocate, and reveals that she might not know exactly to what extent a psychotherapist delves into the issues with her clients.

"Jiena, l-issue tiegħi, aħna, jiena fil-każ tiegħi nirreferi. Is-psychotherapist kif jistgħu jirreferu lill-pazjenti għandna? Għaliex psychotherapist ġeneralment se jmur biex jitkellem his emotional baggage; mhux se joqgħod jitkellem fuq (klijent) jistax jorqod bil-lejl, kemm jien muġugħa..." (lines 853-856)

"My issue, in my case, I do refer. How can psychotherapists refer patients to us? Because, generally speaking, one goes to the psychotherapist to speak his emotional baggage; he is not going to delve into matters like a client's inability to sleep during the night, his physical pain..." (lines 853-856)

This example also illustrates the importance of one's expertise and the knowledge of other related professions. During the focus group, it was amply clear that some participants hailing from the different professions revealed this lack of knowledge. Reacting to the osteopath introducing himself, participant Elena (CT), who is also a complementary therapist, reacts by saying:

"Lanqas kont naf li jeżisti xi ħadd hawn Malta..." (line 102)

"I was unaware that in Malta we had someone (like you)..." (line 102)

"And where is the Centre?..".(line 105)

"How is it different from chiropractor?" (line 112)

Later on during the session, Sophie (PT) also refers to this in relation to the territorial discourse with emphasis on the word 'divide':

U ħafna drabi nara li ma tantx nafu fuq xulxin u allura jkun hemm ħafna misconception u din forsi li toħloq id-divide. (lines 696-697)

"Most of the times, I realise that we only know little about each other which leads to a lot of misconceptions that may create a sense of divide." (lines 696-697)

She adds that the lack of knowledge of each other's discipline might lead to scepticism which may be translated in the 'divide' between the professionals, a potential threat to any possible mutual collaboration.

...illum nista' iktar nifhem x'tagħmlu u anki nħossni iktar komda biex nirreferi. Ix-xettiċiżmu xi kultant joħloq dan id-distakk jew id-divide bejn il-professjonisti differenti naħseb jiena. (lines 702-704)

"...today I am in a better position to understand what you do and I feel more at ease to refer. At times, scepticism leads to the sense of divide between different professionals, at least the way I see it." (lines 702-704)

4.3.1 The participants' understanding of Maltese society and culture

The perceived impact of the small size of Malta, an island of around half a million inhabitants living in an area of 122 square miles, was another territory issue which promoted the majority of participants to discuss. Participants' dominant discourses do not portray the positive side of the local context.

Paul (CT) says that the small size of Malta causes ripple effects. The choice of discourse is quite negative with regards to Malta.

L-ikbar problema tagħna hija l-over-population. Dik hija l-omm ta' kull problema. (lines 972-973)

"Our main issue is that of over-population. That is the mother of all

other problems." (lines 972-973)

Ovvjament, l-edukazzjoni li għedna; ħadd ma jgħallimna nagħmlu dak il-vjaġġ intern imma kollox huwa orjentat lejn il-karriera, run race mindu titwieled, ara inti x'toħloq... Din hija Malta. (lines 986-989)

"Obviously, the educational aspect we have already mentioned; noone teaches us how to make that internal journey, but everything is career oriented, a race from the moment you are born...this is Malta." (lines 986-989)

Kontinwament irridu ngħallmu s-solidarjetà, l-aċċettazzjoni tal-ieħor, qed tifhem? Imma l-edukazzjoni hi wisq orjentata lejn is-suċċess fil-ħajja. Dik qed teqridna. (lines 993-994)

"We need to continuously teach solidarity, mutual acceptance... do you know what I mean? But (our) education is too oriented towards success in life. That is ruining us." (lines 993-994)

More of this kind of discourse was coming from a number of participants from both professions who said that people who seek their professional service might not exactly know what their profession entails, but turn to them just the same because they would have learnt about them from others through the word of mouth, promoting their service as good, one that will surely help them solve their problem. Peter (CT) says:

"In my case it's a lot of...someone had the same problem which has been solved by coming to us and they talk and they refer to us. I had a problem with my shoulder and I went to him...now, whether I'm an Osteopath, whether I'm a ...they don't really know what's your profession. I turned to him and... (I was satisfied)..."(lines 1002-1007)

While other participants nod their heads to approve, Jane (PT) and Amy (CT) agree and say after each other:

"*Word of mouth" (line 1008)*

"That's what I was going to say...word of mouth." (line 1009)

Peter (CT) interprets this as a Maltese cultural phenomenon.

> *"In Malta, backpain, acupunctures can treat backpain, physiotherapists can treat backpain, so they don't give some much notice to that...they simply say "mort għand dak u mort ..." ("I have been to see him at it was...") that's more Maltese, more of a cultural thing". (lines 1014-1016)*

At the same time, I could observe that the power issues discussed earlier also seem to be embedded in the participants' thinking here. The psychotherapists do not appear to be as negative as the complementary therapists seem to be. The former look like more constructive while the latter, being the perceived underdogs, the unacknowledged and unrecognised, look like being more critical. The following psychotherapists' discourse highlights the difference. Jane (PT), who studied abroad and experienced different cultures, says that even if the Maltese are known as 'hard-working', they possibly emerge as lacking self-confidence. She gathers these ideas and links them with beliefs and education in the Maltese culture by saying:

> *"So it starts from giving children of any nation - they don't have to be Maltese but also multi-cultural - the ability to reflect and to form their own ideas and not be ashamed to form their own beliefs, even if their beliefs are different from those of others."(lines 1030-1033)*

Jane (PT) speaks of challenges related to Malta's history of colonialism by saying:

> *"I think, linking with our culture, that this challenge in terms of voicing our needs and being self-assured or open to what we believe, I link it to our history*

of colonialism and it is in our DNA, at least mine as a Maltese, that we kind of, grew up with this idea that people from out there are better than us..." (lines 1108-1111)

Discourse like 'better than us' implies the idea of comparison. It seems that through their choice of discourse, psychotherapists believe that it is important to have others to compare to, especially if they are foreigners. This might give them the opportunity to perform their self-critique and appreciate their professional status. Edmond (PT) adds on:

"I think we are very much influenced by the others in shaping our lives – so the other can also be a professional, can be a doctor, can be a lawyer...so we let other people shaping our lives than us making a decision. So, yes I think that might be a very powerful Maltese cultural force that we have." (lines 1149-1152)

4.4 The process of change

From the participants' discourse on their conceptualisation of the clients' presenting problems and also change, a good two thirds of the participants replied unequivocally, with answers varying from the clients' need to get better to seeking relief from physical or psychological distress. Anabel (CT) gave a clear answer which possibly reflects the conviction that the therapy will yield the desired outcome.

"*To get better." (line 544)*

Elena (CT) reacts immediately with an answer that could be interpreted in two ways: clients seek their therapy because they have exhausted all other avenues of help, to no avail, which also shows that complementary therapists truly feel they are the underdogs, or perhaps that

the clients seek the complimentary therapists as their salvation, which makes up for the lack of social power given to these therapists.

> "*They come (to us) as a last resort." (line 545)*

Paul (CT) pursues the same line of thinking by saying that clients seek their intervention for pain relief.

> "*Sometimes they come for the relief of pain, pain relief mainly. (line 574)*

Edmond (PT) says that people seek his assistance when facing a problem they cannot solve by themselves, possibly connecting the concept of reflection mentioned earlier.

> *"I only think that they really come when they are facing a problem that they can't solve by themselves." (lines 603-604)*

Jane (PT) adds on Edmond (PT) and explains that when some clients manage to solve their initial crisis, they decide to take therapy to a higher level, beyond the problem and its fix.

> *"And to add to that, Edmond (PT), some come for that and stop there, the crisis would be solved and 'OK, we have now decided to separate' or 'OK we are now staying together mela'. But some take it a step further and have you seen that? Some of them become curious for example, 'why do I have a problem with managing my temper?', 'what's this about?', or 'why do I get so sad?', or 'why do I have this issue when speaking with my daughter, we trigger something in each other which I can't explain?' 'Why do I whenever I visit that family member I develop a migraine?' (lines 605-612)*
>
> *And that's where we say the real therapy starts you know, because the crisis is over and now some people get really curious and there we can do very creative work because it's beyond the problem and the fix it and it's about what we need*

to understand about ourselves and each other and develop further." (lines 612-615)

Sophie (PT) indicates as well that people might seek the therapeutic services to nurture their well-being. Jane (PT) subscribes to this and reacts immediately, saying that prevention is always better than cure.

"...qed ngħid li nieħdu ħsieb il-wellbeing tagħna nfusna huwa, u kif qed ngħidu huwa spiritwali, u anke soċjali, u relazzjonali, u bioloġiku u fiżiku, jiġifieri it fulfils the person..." (lines 641-643)

"...I am saying that we need to take care of our own well-being, which as we're saying is spiritual, social and relational, biological and physical; which means it fulfils the person..." (lines 641-643)

"Prevention is better than cure when it comes to holistic health, ideally before it reaches crisis levels, and how it would expose our children to these ideas...exactly." (lines 645-646)

Maria (CT) takes this further and attributes clients' problems to stress, which in her own words leads to a mind and a body imbalance:

Jiena nemmen li 80% of all the chronic conditions that exist are all linked to mind imbalance. Nemmen ħafna li meta persuna tgħaddi minn stress, u sfortunatament illum il-ħajja tagħna hija very stressful, fl-aħħar mill-aħħar if the mind is imbalanced the body will be imbalanced. (lines 811-814)

"I believe that 80% of all chronic conditions that exist are all linked to mind imbalance. I strongly believe that when a person experiences stress, and we know how today life is...very stressful; if the mind is imbalanced, the whole body will be imbalanced." (lines 811-814)

When asked directly how they believe change happens, four participants replied with identifying a personal and a social responsibility. Yet again, the psychotherapists' discourse looked like more insightful than that of complementary therapists. The following extracts, both focusing on social responsibility, are a typical example. Amy (CT) highlights the importance of awareness and education, which is a social responsibility in the first place:

> "*You have to create awareness and education." (line 898)*

Jane (PT) agrees and adds the individual responsibility in pursuing change, backs her claims by research, goes into the therapeutic relationship and reflects on the client's resilience while describing 'change' as a 'miracle' implying it is something of a huge impact, very desirable, and powerful, especially when keeping in mind that miracles are not so common.

> *"Awareness and education...And the person has to be ready for it, in terms of in our field - empirical research over the last decades has shown that the most important factors were actually client factors. They were not what kind of practitioner gave the service, and what titles or qualifications; first was the level of motivation of the service with the client/the journey maker and the level of support that that person had for change." (lines 899-904)*

> *"And then after that was the therapeutic relation but it wasn't actually the qualifications or the modality or the profession. That kind of humbles me as a practitioner in terms of my say in the change. I am just an instrument, I am just the vehicle..."(lines 904-907)*

> *"...but ultimately change is for me like a miracle and it has to do with the person's resilience, the capacity to have the courage to step into the unknown and I think change can be scary." (lines 908-910)*

Earlier during the focus group discussion, Elena (CT) subscribed to this idea of resilience and emphasised the possibility of change through dealing with the here and now, through the openness towards the process and the 'letting go', even when the 'cause' is unknown. She said:

> *"Sometimes you can't always find the cause but usually the cause is embedded in some trauma which the patient is going through. So unless you go there and deal with the mental and the emotional aspects, of that patient, that patient will not be well physically unless they can let go of the trauma at that stage." (lines 341-344)*

Sophie (PT) says change is subjective and Elena (CT) continues by saying that something else people look for is a change in their quality of life.

> *Problema jiena naraha li l-persuna taraha problema, jista' jkun li ma tkunx problema. Jista' jkun li għal ħadd ma tkun problema. It is very subjective naraha of what is a problem. U bl-istess argument anki change. Jista' jkun li int tkun qed tara ċertu bidla, pero fl-aħħar mill-aħħar jekk il-persuna ma jarax ċertu bidla jew il-bidla li jixtieq hu, x'inhi bidla mbagħad? – il-mistoqsija tiegħi. (lines 919-924)*

> *"A problem, the way I see it, is what the person perceives to be the problem. It could possibly be no problem at all. It could possibly be not a problem for everyone else. What is a problem...I think is very subjective, the way I see it. On the same lines also the issue of change. You could be observing a certain degree of change, but if the person is not seeing it or is not seeing the change he wants, then what kind of change is that? – That is my question." (lines 919-924)*

> *Naħseb anki bidla mill-mod ta' kwalità tal-ħajja li jridu n-nies. (line 925)*

> *"I think also about change in the quality of life people want." (line 925)*

4.5 The medical profession: Omnipotent and Omnipresent

Earlier, territory issues were reported, featuring discourse of divide between professionals - the 'us' and 'them' discourse. A general sentiment from the participants was that, at present, the linear thinking and the modern, expert positioning of the medical model is still very dominant in Malta, leaving much to be desired when it comes to a holistic or a systemic approach when dealing with the clients' presenting problems. It is clear that both psychotherapists and complementary therapists involved in this research share this sentiment so much so that the medical profession, although not forming part of the present focus group, was like the proverbial elephant in the room. Psychotherapists seem to have an issue with psychologists and psychiatrists while complementary therapists seem to have one with doctors and the medical profession.

A dominant discourse by participants from both disciplines is illustrated in their discussion about the somatic and the psychic; the body and the mind. For the purpose of this study, the participants' discourse illustrates that the body and the mind need to be more in tune with each other. For instance:

Paul (CT) points out to a circular relationship between the body and the mind:

> *"...See, I practice acupuncture and massage to try and bring back the balance in the body which can affect the mind which can affect the body." (lines 193-195)*

Sophie (PT) speaks against one way of treatment dominating over others.

> *naħseb il-poplu tal-west imdorri u qisu there's a pill for every ill*

tweġġagħni daqsxejn. There's a remedy for every ill ijwa. A remedy, issa, tista' tkun whatever. Imma li jkun hemm xi ħaġa illi jkollha dominanza ħalli ngħidu hekk b'modi oħra ta' trattamenti, ma naħsibx li għandu jkun hemm. (lines 314-317)

"I think that people in the West are used to it, it's like there's a pill for every ill. This hurts me quite a bit. There's a remedy for every ill, yes. A remedy could be whatever. But to have something which dominates over all other kinds of treatment, no. I don't think that should be the case." (lines 314-317)

Jiena fis-psychopathology jiġifieri l-push tiegħi li ma nibqgħux daqshekk il-clinical medical model li hemm illum, basically. (lines 330-331)

"In my case, in psychopathology, I push for a bit of distancing away from the clinical medical model which exists today, basically." (lines 330-331)

4.6 Professional collaboration: In the realm of possibility

Overtly, all therapists were open to collaboration, even though there were instances during the focus group discussion where the choice of discourse could have been made to please other participants. This reflects my awareness of the social desirability bias, which is a type of response bias that is the tendency in social science research of respondents who answer questions in a manner that will be viewed favourably by other present participants.

Referring to a holistic way to deal with clients, Jane (PT) verbalises the need for more possible conversation between the different professions and professionals.

"I think there are counsellors, whatever, even psychiatrists or medicals who are actually very open to these ideas but I think we need to find the way how to make this a more possible conversation." (lines 668-671)

Sophie (PT) sums this up by referring not just to the professions and professionals, but also to their ideologies put in practise. The chosen discourse, especially the word 'co-exist' emphasises the idea of indivisibility of body and mind.

> *Pereżempju psikjatri li jispjegaw lill-pazjenti li, bħal ma għedna aħna wkoll, li d-dipressjoni tqabbdek l-uġigħ u l-uġigħ iqabbdek id-dipressjoni. Ma noqogħdux ngħidu liem ġiet l-ewwel u liem ġiet wara. I mean they co-exist. (lines 779-781)*

> *"For example, psychiatrists who explain their patients, as we said earlier, that depression causes you pain, and pain generates depression. We do not say which came first. I mean, they co-exist." (lines 779-781)*

The 'possible conversation' referred to by Jane (PT) can be interpreted as the need for professional collaboration which seems to be within the realm of possibility. Throughout the focus group session, discourse of collaboration stood out in the following example, which attracted unanimous non-verbal approval. Jane (PT) spoke of her openness to this collaboration in terms of wholeness and connectedness.

> *"I am kind of open to finding more spaces where these two worlds are not two but are one." (lines 445-446)*

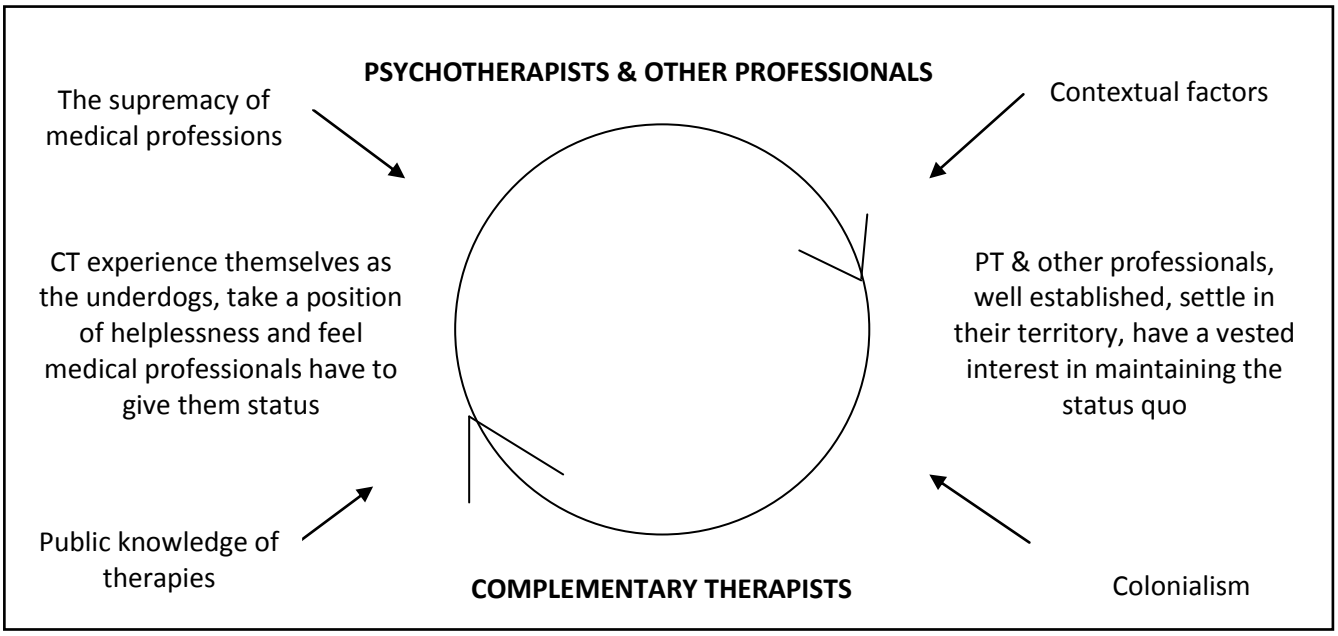
> *...The two worlds, do not need to be two because in my experience they are one in me but I understand the complexity of that especially in particular settings where duality is in operation... For me they are not separate, but I do understand and respect that for many people they can be separate and it can create a lot of discomfort, of fear, but I believe it's a dual position for people who operate from a position of fear. For people who operate from a position of security the two, there's no two, there's a whole. But it takes a lot of courage, it takes a lot of selfnessness to feel safe in diversity and understand that there are more things that connect us." (lines 475-485)*

Chapter 5: Discussion

5.1 Introduction

The main objective of this research study was to explore the relationship between the psychotherapists and the complementary therapists in terms of their professions, disciplines and respective ideologies, their conceptualisation of change and the potential collaboration between their professions. This chapter will provide a systemic understanding of the findings obtained and will discuss the therapeutic engagement and the quest for change; the process of development of the respective professions in the local context; the territory issues in Malta's reality; and the way forward for inter-professional collaboration. The findings of this study are based on the analysis of the resulting data through the process of the focus group which was conducted with a mixed sample of psychotherapists and complementary therapists.

In the different parts of this chapter, I will be referring to my systemic understanding of the different patterns which emerged in the findings of this study. The following diagram provides a snapshot of my systemic understanding of the findings.



5.2 Therapeutic engagement and the quest for change

Hyland (2015) says that meta-analyses show that psychotherapy and complementary therapies are effective primarily or entirely due to contextual factors. He says that therapists are the most important contextual factor even though there are no answers to how or why. Explaining the therapeutic alliance in a contextual framework, referring to the therapeutic bond between the therapist and the client, the client's expectancy of a positive outcome and the shared goals of the therapist and the client for therapy, immediately resonates with what was said and unsaid by the focus group participants in this research. Connecting Hyland's (2015) ideas to the indicated reasons as to why clients seek the respective therapists' interventions, numerous statements during the focus group in this study stood out as very much in line with the literature. Speaking of clients and therapists, therapeutic relationship, and therapy; as a researcher who is coming from a systemic psychotherapeutic background, I cannot forget Flaskas (1997), where she states that "engagement in a systemic context can be thought of as the process of forming and holding a good-enough therapeutic relationship so that the work of a particular therapy can occur".

As the findings revealed, client factors and therapeutic relationship in the process of therapy were identified as crucial for the experiencing of desired change. This included the level of motivation of the service with the client/the journey maker and the level of support that person had to change. Essential in all this was the person of the therapist, his/her way of contributing towards the establishing of the therapeutic engagement, together with the time and attention he/she invests in therapy. It was interesting to note that psychotherapists said that a therapeutic relationship built upon trust between the therapist and the client leads to exploring in therapy other aspects besides than understanding and deconstructing the

presenting problem. Expecting complementary therapists to subscribe to this and share their experience, I was quite surprised to observe that only some of them felt the need to approve of what the psychotherapists were saying through their non-verbals, particularly through nodding their heads.

This made me think how psychotherapists seemed to reveal more self-confidence and depth. When asked around their understanding of what constitutes a problem, psychotherapists spoke about the subjectivity of each problem and the importance of a collaborative understanding of its meaning and context from the client's perspective. When asked why clients seek their professional interventions, the psychotherapists accentuated the quest for a change which is more second order. They explained how thanks to a strongly built therapeutic relationship, clients do not just seek to solve their presenting crisis, but may also become curious and take therapy to a higher level by stepping into the unknown and look for change in other arising issues in therapy. In my opinion, also from my little experience of family therapy, clients come to therapy with a preoccupation with finding the cause and the location of a problem. The interesting process starts by exploring the extent to which this preoccupation is contributing to the problem with an emphasis shift from a concern with the etiology of the problem to a concern with the meanings that are attached to it (Hoffman, 1985).

In contrast, complementary therapists participating in this study, who emphasised the need of a positive relationship with their clients and the allocation of appropriate time to their therapeutic needs, seemed to reveal a lack of self-confidence and depth when they came to answer questions around their understanding of what constitutes problems and their conceptualisation of change. The complementary therapists only expressed their views that

problems stem from a body-mind imbalance and from unexpressed emotions and that people seek their help as a last resort, after exhausting all avenues to no avail. Asking them to say a bit more and backing it with their professional experience, complementary therapists seemed to be stuck and lost for words. In my opinion, this could be due to their lack of training in self-reflexivity.

Interestingly, the difference in self-reflexivity between psychotherapists and complementary therapists emerged when the participants were asked for their ideas around the cultural context playing a role in the discussion about both professions and disciplines. Through the way they spoke, complementary therapists seemed to be more certain of what they do, possibly because they wanted to prove themselves and their experience, especially when feeling less acknowledged when comparing themselves to other professionals. Psychotherapists showed more humbleness, especially when they spoke of accepting their own limitations, possibly giving them more security and a steady ground to be more irreverent (Cecchin et al., 1993) with their clients. In the focus group discussion, psychotherapists seemed to be more cautious on how to choose their words and on how to locate themselves and other professionals in their discourse. This reminds me of Harre's positioning theory which stipulates that people in conversation with one another assume ways of being that are situated within particular socially constructed discourses and discursive practices that include assumptions about rights, responsibilities and entitlements (Harre, 2012). In this study, positioning seemed to be more evident for psychotherapists who appeared to be more confident to take up and negotiate their place in the conversation, shaping identity through communication, which is the shared social-constructionist approach of social psychologists Jonathan Potter and Margaret Wetherell, psychologists Rom Harre

and Bronwyn Davies, and sociologist Luk Van Langenhove who are most often seen as the founders of positioning theory (Kroløkke, 2009: 765).

5.3 The professions' process of development within the local context

Going through the findings of this research, it was quite remarkable to note how some complementary therapists contributing to this study explicitly said that clients seek therapy as their last resort. This does not concur with my literature review. My interpretation of it is that there seems to be a local issue of stigma which, possibly, still exists around the complementary therapies.

Besides that, one naturally asks to what and to whom clients turn to before approaching complementary therapists for their therapies. This leads me to point out one very significant area which although not explicitly included in the research questions, it was felt throughout the whole study in both what was said and not, both in the dominant and in subjugated discourses. I am referring to the medical field. As I had the opportunity to say earlier, professionals in the medical field have a lot of power and influence locally, as is the situation globally. In my opinion, these complementary therapists were referring to doctors as their clients' first resort. There were numerous instances in the focus group discussion where they expressed themselves on these same lines, revealing a mild sense of antagonism towards the medical field. In fact, as reported in the findings, complementary therapists seemed to consider themselves as the underdogs. This feeling could possibly be embedded in the history and the development of the healthcare landscape in Malta, which is in a rapid state of flux, as are the metrics for gauging its profile, diversity and effectiveness (Cacciottolo, 2016).

As for the psychotherapists, there was also a time when they too considered themselves as the underdogs to psychiatrists and psychologists who had more social status. Back to the early 1900's in Malta, it was only the family doctor or the priest who were socially known as the main or the only reference points. One could say that in Malta it is only now that psychotherapists are slowly establishing their social status, with a law to regulate their profession still at a parliamentary debate level, generally considered as 'works in progress'. At the same time, the profession of complementary therapists in Malta is still very peripheral. In fact, the vast majority of complementary therapies are not a regulated profession. Formally, in Malta's public health system, one can only find acupuncture which is offered as part of the healthcare services at Mater Dei hospital, which is the main public hospital in Malta.

My interpretation of this is that the Maltese people's level of trust in the complementary therapies' profession is still low, a factor which at the same time is highly indicative of lack of public knowledge and awareness around what the profession involves. The latter is in line with the literature. For example, Brolinson, Price, Ditmyer & Reyes (2001) studied nurses' attitudes, knowledge and use of non-pharmacological pain management techniques and therapies, finding that many nurses did not know about complementary therapies and that there was a great need for continuous professional development regarding these options in the health system. In the same research, nurses were asked about the safety of these therapies as well as their use. 79% of the respondents perceived their professional education in the area to be fair or even poor, suggesting that this area will be included in the basic baccalaureate nursing education curriculum. This clearly shows that until 15 years ago in the US, the lack of professional preparation, public knowledge and awareness of the subject was very lacking amongst caring professions, let alone in the general public fora.

In the case of psychotherapists, the situation in Malta has registered progress over the last number of years through the widening of the spectrum of studies in the psychology field. Eventually, besides private post-graduate courses in gestalt psychotherapy, the Institute of Family Therapy (IFT-Malta), founded in 2011, embarked on training students in systemic psychotherapy and family therapy, and also through similar training courses which since then have also been introduced at the University of Malta. Today, psychotherapy is a more acknowledged profession and gradually one can observe several public calls offering job opportunities to qualified psychotherapists and family therapists not just in the private sector but also in government agencies and hospitals. This is a clear sign of integrating the psychotherapists' profession in the multi-disciplinary professional framework which had been already in place.

As for the complementary therapies, in contrast to what happens in the US, the UK and other countries, in Malta they are not integrated in the health system. Given that this is a systemic research, one could systemically hypothesise that as complementary therapies are still part of our subjugated stories, professionals behind these therapies could be presenting themselves as having identity issues, especially when they compare themselves to other caring professions. The general lack of knowledge about what they do, possibly impacts their power status in a negative way because knowledge is a source of power Baldwin (2007). This possibly leaves complementary therapists helpless and consequently they could be segregating themselves in their professional territory, rendering them insecure. This may force them to constantly seek acknowledgement and validation from other professions and from the rest of society. As a result, they complain of identity issues, with the circular pattern repeating itself, leaving them stuck in their territory. Thinking around what they can do different to break that circular pattern is much appropriate, particularly through empowering their self-esteem, increasing

their public presence by sharing their knowledge and creating more awareness and through approaching other professionals for mutual collaboration.

5.4 Territory issues in a reality called Malta

Ironically, what came out quite strongly from the findings was the territory issue related to Malta. Psychotherapists and complementary therapists in this study emphasized the fact that Malta's colonialism's history might have been and possibly is still influencing the Maltese people's beliefs that, for example, foreigners know better or do it better than them. This could influence an individual's self-esteem so much so that even if one is a professional, possessing academic qualifications, he/she would possibly sense the need of someone else's blessing to feel his/her professional power and social standing is acknowledged. Another point both psychotherapists and complementary therapists emphasized is the small size of the country where people live in a face-to-face community (Abela, 2015). This possibly makes way for a quicker spread of the word. I interpret this as their need of people seeking their professional help to validate their professional status in the Maltese society. All of this possibly reflects the emerging patterns in the findings of this research. On one hand, psychotherapists seem to reveal themselves as more secure, which security, coming from a general public sentiment of acknowledgment of their professional status in Malta allows them to be less bound to their territory and thus more collaborative with other professionals like psychologists and psychiatrists. On the other hand, complementary therapists seem to feel less acknowledged by the general public sentiment, thus more insecure and strongly tied to their territory, in need of other professionals' blessing, mainly of doctors, to be able to get their desired acknowledgment and liberation leading them to explore further collaboration. Metaphorically, it seems that both psychotherapists and complementary therapists are in the

same pond with the immediate question being: Can they both call themselves fish? Another question would be: Does recognising one's professional authority as a therapist mean granting him/her access to my professional pool? As reported in the findings of this study, it is about the lack of official recognition, social positioning and pecking order in the respective professions.

Referring to the ubiquitous presence of the medical field as a key player in this discussion of the journey of psychotherapists and complementary therapists in the Maltese society, as highlighted by the findings of this particular study, research also contributes to the understanding of territoriality and power in the health professions. Baldwin (2007) refers to this phenomenon when he said that the health care system today has become substantially more complex and differentiated. Such have been the opportunities and demands of this growing complexity of medical care that, over time, the unitary concept of the physician has split apart into various specialties, each with its own powerful claim to a special identity, status, autonomy and, essentially, monopoly (ibid.). "Although medicine has continued to demand and hold power and authority in health care decisions, there have been clear signs of a growing desire for a place in the sun from the various workers in the health enterprise who, meanwhile, have been specializing themselves" (Baldwin, 2007). As progress unfolded, mounting challenges from nursing and the other health professions and occupations have made the boundaries of medicine's traditional power and territory an area of dynamic tension and change. This highlights the importance of establishing professional territory and holding on to it amidst the existing insecurities, which was also reported in the findings of this study.

Along the years, progress has led to the emergence of a vision of overlapping territory and of open and flexible boundaries, as one possible area of fruitful discussion and negotiation between health groups striving for a place in the sun. Epstein (2014) elaborates on the idea of

multidisciplinary work of professionals in healthcare and says that it improves outcomes. Negotiating and clarifying individual roles within a multidisciplinary team, developing a common sense of purpose, gaining the commitment of all team members, innovative organisational structures and the explicit support for multidisciplinary work from the healthcare system have been identified as "facilitators" towards the development of efficient and effective multidisciplinary care (IHE, 2006). Speaking of territorial marking, Baldwin (2007) says that rather than provoking conflict and confrontation at the boundaries by passionate displays of power and prejudice, open discussion and cooperation may be a more fruitful way of negotiating border disputes. In my opinion, such contributions enrich this study which is exploring the relationship between the complementary therapies and the psychotherapies in Malta as professions and disciplines. Both psychotherapists and complementary therapists in this study summed up these thoughts when hinting the importance of collaboration.

5.5 Inter-professional collaboration: A way forward

Keeping in mind that both psychotherapies and complementary therapies fall under the healthcare profession umbrella; that both of them seek to help the clients acquire the desired change; and that both of them do this through talk and manual therapies respectively before resorting to medicine; I think it is justified to explore ways of collaboration.

In fact, as expected, the collaboration between the professions was another emerging theme which was reported in the findings of this study. Axelsson, S.B., & Axelsson, R. (2009) say that the collaboration between different professions has become more necessary in modern society, especially in view of the increasing specializations and increasing professionalization

of occupational groups engaged in the provision of different services. Meads & Ashcroft (2005) refer to this as well and say that it is particularly the case in health and social care. The fragmentation of services, as Miller & Ahmad (2000) call it, requires inter-professional collaboration, but in practise also inter-organizational and sometimes even inter-sectorial collaboration (Axelsson & Axelsson, 2006).

In this particular study focusing on the psychotherapists and complementary therapists' professions and disciplines, it has to be said that in Malta, it is only the psychotherapists who are officially practising in multi-disciplinary teams which have been established in different public agencies. This probably explains their openness to collaboration as reported in the findings of this study. The same openness to collaboration is also mirrored in the conceptual framework of psychotherapists who choose to take the systemic training which in itself encourages collaboration. This was also manifested in their self-confidence and security with which they expressed themselves in the focus group, while remaining tentative and self-reflexive. On the other hand, one understands why the complementary therapists assume the underdog position while struggling for their professional status and social power, revealing a level of insecurity and lack of self-confidence. This is because their professional practice is still very far away from making it to the public agencies, with the exception of acupuncture, mainly. In the private sector, for a complementary therapist to join a multi-disciplinary team, is still in a pre-mature stage. That said, delving into the focus group session at the core of this study, one also understands the uneasy feeling when the osteopath, a complementary therapist himself, said that almost two years on, his new profession in Malta has been regulated and is attracting clients also through collaboration with the medical profession. My interpretation is that the rest of complementary therapists envy such recognition, because it still lies within their wishful thinking.

A particular key to this inter-professional collaboration, as the psychotherapists and the complementary therapists argued in this study, is the knowledge of each other and creating more public awareness. In my opinion, this is something which takes time and requires a positive and proactive attitude. Axelsson, S.B., & Axelsson, R. (2009) discuss this subject with empirical data from a case study of collaboration in vocational rehabilitation and declare that it takes time to realize the competences represented in the multi-disciplinary teams and the use they can have of each other. They say that in the beginning, there was mutual suspicion between the professional groups, which was based on a lack of knowledge of each other and also on prejudices resulting from territorial thinking. Gradually, a lot of this suspicion has been replaced by positive experiences of being able to accomplish more together for the vocational rehabilitation of the clients concerned. They add that a condition for such an altruistic attitude is, however, a high level of trust between the individuals involved, which requires a continual participation in the collaboration process. Axelsson, S.B., & Axelsson, R. (2009) propose and explore the concept of altruism as an alternative to territoriality, overcoming existing barriers.

As was very clear in the findings, both psychotherapists and complementary therapists have a lot to offer through their respective talk and manual therapies which are different to what other professionals in the healthcare sector do. As for the psychotherapists, it seems that they are faring quite well, not just by establishing their presence publicly, but also through professional conversations with other professionals like psychologists and psychiatrists. What also seems to be keeping the complementary therapists back is their own reinforcing of the hierarchy, which, as explained before, is still possibly seen by the Maltese society as dominated by the medical profession. As they subconsciously seemed to reveal in this study, complementary therapists do this through their individual work and their holding of territory

which makes them continuously seek acknowledgement from doctors and other medical professionals, which in itself translates into giving the latter professionals more power.

The concept of altruism, explained by Krebs & Miller (1985) as the ability to transcend and sacrifice particular interests for a common purpose, makes a lot of sense in this scenario. Intertwining this with the concept of altruism as discussed by Axelsson, S.B., & Axelsson, R. (2009), the argument can be easily applied to psychotherapists and complementary therapists who both work for a common purpose which is the betterment of their clients. In my opinion, this requires both types of professionals to come together, understand each other's work better, share knowledge, and discuss how they can apply the 'both/and' idea proposed by Andersen (1992) to their respective disciplines which although possibly holding different values, concepts and knowledge bases, they can still contribute to shared aims. Frost and Robinson (2007) said that shared aims can be general enough to allow for different specific values and can be functional in relation to broad questions such as 'how can we address this problem?' The literature also indicates that once a joint aim has been established, there is a need for a clear strategy for achieving collaborative working (Harris, 2003; Tett and others, 2003).

Chapter 6: Conclusion

6.1 Introduction

The aim of the research was to conduct a discourse analysis whilst exploring the relationship between the psychotherapists and the complementary therapists' respective professions and disciplines in Malta. The foregoing chapters examined how the two professions and disciplines complement each other, what the respective professionals know about each others' disciplines, what their ideas of problems and change are and if the professionals within the two disciplines seek each other's therapies, possibly also referring clients to each other's form of therapies.

The research questions were examined through a qualitative approach in the form of a focus group. The use of a focus group with a mixture of psychotherapists and complementary therapists allowed for more in-depth insight into their understanding of each other's work and their ideas around what makes a problem and the conceptualisation of change. This made way for an open discussion, making the analysis of the findings more meaningful. A review of the relevant literature was also presented, and finally an interpretation of the findings obtained was provided along with a discussion of the emerging themes. In this chapter, I will not just present my concluding reflections and remarks, but I will also mention the limitations of this study together with recommendations for future research.

6.2 Limitations of the Study

A major limitation of this study was the fact that I didn't invite the medical doctors to participate in the focus group. As already explained, their ubiquitous presence in the psychotherapists and complementary therapists' discourse was very strong and their physical presence and participation in the focus group would have enriched the research with added meanings, allowing for a more comprehensive analysis of the study.

Even though the focus group proved to be very useful in gathering meaningful data from the participants, another limitation was the element of imbalance in the number of participating professionals, with complementary therapists outnumbering the psychotherapists. Additionally, seven out of the nine focus group participants were female. This could have potentially reflected more the views of women. At the same time, my gender as male might have influenced the dynamics of this study. Had it been conducted by a woman, different outcomes could have been generated.

Another limitation of this study is the generalizability from a small sample size. While a sample of nine is within the normal range of focus group compositions in qualitative research design, it is nonetheless a small sample and potentially limits how much one can generalize the results to the Maltese population at large. Another limitation relates to my declared bias as a researcher, especially when I came to make my interpretation of the findings, mainly because of my relationship to my partner who is a complementary therapist. While I was constantly aware of this bias till the very end of the research process, I still feel confident to have achieved valid findings which can serve as a good stepping stone for further research.

6.3 Recommendations for Future Research

This study explored the relationship between the respective professions and disciplines of psychotherapists and complementary therapists in Malta; what the respective professionals know about each other's discipline and what are their ideas of change. Firstly, it would be important for future research to feature in the medical doctors and possibly psychologists and psychiatrists. This would certainly broaden the perspectives and build upon existent research, especially when it comes to inter-professional collaboration in the healthcare profession. It would be recommended that additional studies explore also the perspectives of clients for both therapies, as well as their ideas around what constitutes a problem and their conceptualisations of change.

For further research on the collaboration between these professions and disciplines, it would also be recommendable to explore the challenges of the combination of psychotherapy and complementary therapy, with more emphasis on the body-mind relationship and embodiment in the context of fresh psychosomatic studies and neuroscience latest research. The emerging data will most probably help in understanding the full experience of clients who make simultaneous use of both therapies, as well as in how to approach dealing with challenges towards the optimal integrative experience of both.

6.4 Concluding remarks

Personally, as a researcher, I embarked on this research from a particular position. The fact that my partner is a complementary therapist herself and that I come from a systemic, psychotherapeutic training background, makes us both aware that what we do individually,

the bodywork by the complementary therapists and the psychotherapeutic work by the psychotherapists, supports the client holistically when there is close collaboration between professionals.

This body-mind connection was in fact another theme that featured in the reporting of the findings of this study, with participants from both disciplines highlighting the circular influence of the physical on the psychic and vice versa. This reminds me of being with clients with a sensitivity to the 'livingness' of things, to living, bodily events, both the therapist's own and those of his clients (Anderson, 1992). The important events of life do not simply occur inside the person's head, in his/her mind, but in the person's whole body, his/her whole being (ibid).

This research study is the first in Malta to explore the relationship between psychotherapists and complementary therapists and their respective professions and disciplines. It will surely enrich the existing research in both fields. It is my sincere hope as a researcher that this study contributes to the growing body of knowledge of both disciplines, leading the Maltese to understand more the importance of a multidisciplinary approach in the process of healing oneself holistically, by looking at the mind, the body, the spirit and the emotions as a one whole integrated thing.

Through all of this research process, the participants made me appreciate more how the cultural context influences everyone's set of beliefs and how this is kept alive through language and practise. Also, how important it is to self-reflect and challenge own thoughts and beliefs, how essential it is to open up, share ideas, listen to the field and collaborate with other professionals sharing common aims.

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APPENDIX A

INFORMATION SHEET

A Research Project making way for discussion between Psychotherapists and Complementary Therapists about the relationship between their respective professions and disciplines within the Maltese context.

Introduction

I would like to invite you to participate in this project, which, through a focus group, will explore meanings, conceptualisations and attitudes of therapists in the two different professions around their respective disciplines. I am interested in how both describe their work, what they know about each other's profession, and if, and/or how both see the relevance of the other within their respective profession.

Why am I doing the project?

The project is part of my final year for my Masters course at the Institute of Family Therapy (IFT-Malta). It is hoped that the research project could provide useful information for psychotherapists as well as for complementary/alternative medicine therapists about the relational aspect characterising the potential collaboration between the respective therapies.

What will you have to do now that you agreed to take part?

You will have to sign the attached consent form, giving me permission to record the interview.

1. The session will be organised on Friday 12th May 2017 at Mount St Joseph Retreat House, Targa Gap, Mosta.
2. The focus group of around 10 persons, will take an open discussion format. I will take the moderator role. The session will last around 2 hours, between 5pm and 7pm.
3. When I have completed the study I will produce a summary of the findings which I will be more than happy to send you if you'll be interested.

There are no right or wrong answers to the focus group questions. The research project makes way for as many different viewpoints as possible and it is hoped that every participant expresses his view freely. Your honesty is solicited especially when your views differentiate from those of other participants in the group. All responses from the different participants, which will be encouraged to be expressed one at a time, will be kept confidential.

How much of your time will participation involve?

The session will take no more than 2 hours.

Will your participation in the project remain confidential?

Your name will not be recorded and the information will not be disclosed to other parties. Your responses to the questions will be used for the purpose of this project only and I will not have access to any of your records. You can be assured that if you take part in the project you will remain anonymous.

What are the advantages of taking part?

It is an opportunity for you to speak about your own professional work. Besides that, you may find the session interesting as it will also give you an opportunity to learn about other therapies; share your views, give your experience, share your knowledge; and/or sound your scepticism/different views. You may also find your participation satisfying especially when acknowledging that you will be supporting an under researched area of study in a field.

Is participation in this study voluntary?

Yes, your participation in this project is entirely voluntary. You've been approached as you are one of the professional therapists working in the particular area which is being researched in this project, with a view that your ideas might help in generating new data in the respective fields.

What happens now?

In acceptance to volunteer as a research participant to this study, you are kindly being asked to fill in the consent form below, consenting also the recording of the session. Should you have queries, do email me on karljwright79@hotmail.com or give me a call on (+356) 99458781.

Researcher:
Karl Wright, Institute of Family Therapy (IFT-Malta)

Supervisor:
Mrs Karen Bishop, Institute of Family Therapy (IFT-Malta)

APPENDIX B

Consent to Participate in a Research Study
IFT-Malta

Title of Study: Psychotherapists and Complementary Therapists: A discourse analysis exploring the relationship between the two professions and disciplines in Malta

Introduction

You are being asked to participate in a focus group as part of this research study exploring the relationship or lack of it, between the two professions and disciplines.

You were selected as you are one of the respective professional therapists under research. It is hoped that the research project could provide useful information for psychotherapists as well as for complementary/alternative medicine therapists about the relational aspect characterizing the potential collaboration between the respective therapies.

Confidentiality

This study is anonymous. I will not be collecting or retaining any information about your identity.

The records of this study will be kept strictly confidential. Research records will be kept in a locked file and all electronic information will be coded and secured using a password protected file. I will not include any information in any report that may be published after the study completion, which would make it possible to identify you.

Consent

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you've read and understood the information provided in the research information sheet. You'll be given a copy of this form to keep.

Participant's Name : _____

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

APPENDIX C

Focus Group questions:

1. Introduce yourself by saying what your qualifications are, saying something about your work/practise, how do you describe yourself/your services...
2. From your standpoint, what are your ideas about why people seek your intervention?

   Why do people have problems in your opinion?

   How do you conceptualise change? How do you think that change happens?
3. When do you feel the need to refer? At what point?

   To what kind of profession/s/als do you usually refer to?
4. What are your thoughts about each other's profession?
5. What are your curiosities on each other's therapeutic work?
6. Have you ever looked for each other's therapies?

   Any experiences or encounters?
7. Ever got referrals and/or referred clients to the other respective therapy?
8. Can you see the two therapies collaborating? How?
9. What are your ideas around the Maltese cultural context playing a role in all this?
10. Is there anything else you want to say or anything you think we might have left out?

APPENDIX D

The following is an example of the process of coding and method of analysis taken from the focus group interview. As explained in the methodology, during reading over and over again the transcript, line-by-line coded in the left margin, the researcher took preliminary notes in the right-hand margin which eventually constituted the themes reported in the findings section.

1024		than what you do' – that might possibly reduce the possibility of multi-	Small country = territory
1025		professional collaboration, so because we're a small country and people might	
1026		kind of prefer to hold to their territory.	
1027	Amy	I have experienced that first hand. You can't possibly give a client or a patient	Assumption you can give everything?
1028		everything because they will come with all kinds of challenges and issues and	
1029		problems and conditions. And when you collaborate the interest is in helping and	
1030		healing that person; when you are greedy and 'you think: no, no, no, I don't want	
1031		to share', you give out bad energy and patients and persons equally feel that and	
1032		it's not a nice thing. And even between therapists, as you said, it's, you know...I	
1033		had that few weeks back when I was asked to help somebody and there was a bit	
1034		of miscommunication and I said 'It's fine, just explain yourself better'. But you	
1035		just can't service the whole island. It's great that you are busy but you can't do	Ambivalence?
1036		the whole island on your own. And what I give, in my massage or whatever it is,	
1037		it's gonna be different and someone else is gonna need that and equally to	The need of each other's professions
1038		whatever you do there are other people who resonate with you or may be they	
1039		want to come back and forth. So yes, that is a huge problem I feel.	
1040	Edmond	What I want to add to your point is that, I don't know if it's a cultural	Culture?
1041		phenomenon, but I would say there's a bit of lacking when it comes to	
1042		reflexivity. I'm not just a therapist but I am also a human being so my story	Reflexivity limitations
1043		influences my practise and it also influences my limitations. As a therapist there	
1044		is no...It's not possible for me to work with every kind of family or every couple.	
1045		So, I would see it, I don't know, in my context. I won't say cultural because may	
1046		be I don't know enough. But I would say in my context I see a lot of lack of	Lack of reflexivity
1047		reflexivity so I am happy when I also hear you saying that you recognise there's	
1048		limitations in this aspect of my work and you refer to somebody else. And I think	
1049		that's what we need more of in the local context. And also this awareness of	Awareness of limitations vs excessive pride
1050		limitations, I think, maybe connecting to what you were saying, I see a lot of this	
1051		excessive pride like 'I know how to handle this and I can solve this problem'.	
1052	Amy	The more specialised you are the better you serve your clients and yourself in	Linked to expertise?
1053		your, as you said, your personality, in your career, in what you're doing even in	Reflected back on the profession
1054		yourself infact.	
1055	Edmond	Yes, yes, and I think but it's all an automatic process the more experienced you	Discourse of power's accountability & professional boundaries
1056		become, the more years you practise, the prouder you become of whom you are,	
1057		and it makes you lose sight of the connection with where you are and what your	
1058		limitations are and whether, I would add to that, I believe a lot also in	
1059		supervision, having outside help; not just referring to other people but also	
1060		support for myself as a therapist, which I see as very important to helping me	Reframing seen as lack of competence? Elements of education?
1061		look at myself because I can only look at myself, certain aspects of myself. Other	
1062		people can see other aspect I can't.	
1063	Amy	The coach always needs to be coached and the therapist always needs to be	
1064		(therapied) laughs.	

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