COMMUNITY PSYCHOLOGICAL PERSPECTIVE OF PSYCHOTHERAPY: A CONTRADICTION?

Bernd Roehrle[*] & Janina Strouse[**]

Evidence indicates the need for including environments and contexts as a focus for psychotherapy; however, the field continues to neglect these elements. The consideration of effective psychotherapeutic processes also tends to lack a prevention-based value orientation. This article provides a first step for closing this gap, by including value-driven and contextually oriented theoretical approaches (e.g. ecological models, recovery models, capability approach, sense of community, empowerment) that are essential for psychotherapy in a community psychology perspective. As a second step, this article emphasizes the need for integrating psychotherapeutic interventions with different preventive strategies. Finally, the article summarizes the additional value that community psychological factors bear for increasing treatment efficacy.

Keywords*: psychotherapy, context, ecology, capability, recovery, prevention*

1. Introduction

Community psychology has always faced questions regarding its values, cultural, and social issues in terms of the well-being of psychotherapy patients and their living circumstances. Gendlin (1968), a humanistic-oriented psychotherapist, suggested that regardless of the treatment modality, psychotherapy needs to change from its limited view of individual processes to a consideration of well-being in living environments. Psychotherapists were expected to consider systems such as family, education and employment of their clients when operating from a community psychology perspective. In his view, extramural and preventive care systems would also improve the living environments for clients. Gendlin gives a perspective in which community psychology values like social equality and a sense of belonging hold a more important role in psychotherapeutic and prevention oriented work. Since Gendlin's fundamental perspective, few well known contributions have focused on any reciprocal exchange between community psychology and psychotherapy. When the term community psychology surfaces in

[*] University of Marburg, Germany
[**] Chestnut Hill College, Philadelphia, PA, United States

the context of psychotherapy, authors frequently limit it to conveying a basic understanding of community psychology to their audience (Kim & Cardemil, 2012). Other authors appear to approach psychotherapy critically, concluding that psychotherapy has detached itself from social realities (Orford, 2008). However, the alienation from social reality is not only relevant for psychotherapy but also for preventive approaches, which are highly recommended in community psychology. Other core values of community psychology, like social equality or cultural differentiation, are overlooked. Avissar (2016) claims that psychotherapy in general has lost its sociopolitical narrative by neglecting these important factors, including human values, and by failing to use interlocking prevention strategies.

Common psychological treatment modalities, such as behavioral therapy, psychodynamic therapy or humanistic approaches all neglect the complexity of social environments. Many psychotherapists from these perspectives overemphasize the meaning of individualistic and small environmental categories, at the risk of viewing psychotherapeutic contexts as resulting from irrational cognition, internal conflicts or self-actualization struggles.

Despite the statements of Altman (2009) that psychodynamic practice is influenced by a variety of contexts, this approach reduces culture to processes of transference and countertransference, forms of common unconscious defense mechanisms, and only to subjective representations of society, culture, organizations and networks (e.g. Hinshelwood, 2005; Koh & Twemlow, 2016; Liang, Tummala-Narra & West, 2011; Tummala-Narra, 2013; Wachtel, 2014). Community oriented psychodynamic interventions are limited on supervision (Fine, 2007). Client-centered therapy, as one form of humanistic psychotherapy, shares religious values with western countries and, more recently, approaches reconstruction as a spiritual event as defined in positive-psychology-based psychotherapy school (e.g. Fuller, 1982; Schneider, 2015). In gestalt-oriented approaches, psychotherapeutic intervention and a change in community work is a focus of the so called gestalt circle, in which the fulfillment of need is the leading element (e.g. Argentino, 2001; Maurer & Gaffiney, 2005).

Behavioral therapy reduced culture, society and social relationships to situations, conditioned stimuli and the exchange of reinforcements (Staats & Staats, 1963; Skinner, 1978). In an extreme form, this idea was conceptualized as potentially creating a utopian society, "Walden II," in which reinforcement principles serve as guidelines for a happy and equal society (for a review, see Altus & Morris, 2009). Social phenomena are reduced to the exchange of reinforcers, minimizing the influence of inner processes, as part of the black box theory. After the cognitive revolution in behavior therapy, the inner world was reinvented, and contexts of behavior are now subjectively reframed as expectancies, subjective theories and attributions more or less rational or irrational. The structure of contexts, even social morality, is minimized to internal representations or learning by imitation (Bandura, 1986). As personality traits, cognitions (e.g. knowledge) can represent economic and social indicators in society (Rentfrow, Jokela, & Lamb, 2015). Some authors believe that offering behavior therapy in community settings is contextual enough (e.g. Prendergast & McCausland, 2007).

The reduction of complex phenomena, in terms of different psychotherapy schools, oversimplifies the world by reducing context in small environments like primary groups or the therapeutic relationship, and by overlooking important aspects of social, cultural and political life in social networks, organizations, communities, societies and/or culture. And, in doing so, become stunted by a sort of clinical pragmatism and belief system that lacks reflection in terms of more complex contexts (e.g., Baruch & Fearon, 2002). This critique further claims that this limited orientation may subsequently lead to economization, modularization, medicalization, as

well as to a shortened view of social problems. According to Orford (2008), psychotherapy is therefore missing opportunities to establish meaningful categories. On the other side, King and Shelley (2008) refer to Adler (1938), who emphasized a sense of community as a possible social basis for psychotherapy.

The individualized form of psychotherapy is mainly seen as a reductionist way to understand the problems of clients. This individualizing view of psychotherapy is obvious when we consider access to care. While access to care has expanded in some countries (e.g., Germany) since the 1990s, so has the need for care, especially in older adults, as well as in people in social distress. The National Institute of Mental Health (NIMH) estimates that only half of the population who suffer mental illness receive treatment. The rate of pharmacotherapy for depression as a special form of individualized reductionist help has increased (Gibbons et al., 2011). It is possible that the type of disorders, diagnoses, or the needs for care have changed over time. However, there are increasing signs that new societal realities, such as economic downturns or changes in people's work environment, have contributed to increases in psychological disorders, despite the growth of psychotherapeutic services (e.g. Uutela, 2010).

A practice of psychotherapy that ignores these facts and corresponding contextual factors appears to be more like a repair service than it does psychosocial help. In addition to access-to-care concerns, numerous ethical issues exist, especially discrimination against people with mental health disorders. People with a low socioeconomic status statistically occur with both higher frequency and severity regarding mental health disorders; however, these populations are frequently undeserved by both research and psychotherapy. The same may be said for different ethnic groups, children, and senior citizens. Several large studies provide evidence that these groups receive less intensive and less frequent psychosocial care, even in countries with otherwise stable access to mental health care (Epping, Muschik & Geyer, 2017; Muntaner, Ng, Vanroelen, Christ & Eaton, 2013).

Poor communities offer less psychosocial care and expose their members to higher stressors (e.g., unemployment, trauma, violence). Meta-analytical evidence shows the relationship between employment status and therapeutic success (Finegan, Firth, Wojnarowski & Delgadillo, 2017). Additionally, only a basic implementation of social supports seems to occur, especially in highly populated areas with low socioeconomic status (Goodman, Pugach, Skolnik & Smith, 2013; Griner & Smith, 2006; Santiago, Kaltman & Miranda, 2013).

This deficiency of caring alone stresses the importance of a stronger contextualization of psychotherapy. To increase access to a form of psychotherapy that considers living environments, community psychology concepts can be utilized (e.g., resources, social networks, sense of community, coping, resilience, empowerment, identity formation, prevention). Empirical evidence suggests the benefit of these concepts, illustrating a potential ecological framework of community psychology for psychotherapeutic practice.

2. Community Psychological Contexts of Psychotherapy

Several central ideas connect community psychology with psychotherapy in contexts: First, Bronfenbrenner's (1979) views of socialization are also applicable to the world of psychotherapy, and can also be viewed as concentrically organized in interdependently working circles. Secondly, the integration of a more value-oriented psychotherapy in the sense of community

psychology goals emphasizes equality and provides the opportunity to develop personal resources, empowering people to work out individual and collective mental health, even in a psychotherapeutic context. Third, the view that psychotherapeutically important living environments are, like biological habitats, organized with access to resources and alternatives for action, may broaden the narrowed perspective of existing psychotherapeutic schools (Kelly, 1986).

2.1. The Concentrically Organized World of Psychotherapy

The first idea, oriented on Bronfenbrenner's (1979) ecological model, differentiates between microsocial immediate environments and higher order meso-, exo- and macrosocial living conditions, to open up direct and indirect ways to reconstruct the influence on social aggregation and the behavior of individuals (see Monterey Declaration of Critical Community Psychology, 2011). This idea is also closely related to an early concept by Orlinsky and Howard (1987) and Orlinsky (2009). These ideas focus on complex interactions between therapist, client, team, social network, care conditions, care systems, and social conditions. Macrosocial contexts are expressed through cultural, judicial, political, and economic factors. In an effort to identify influencing factors, therapist-client relationship has been the primary focus of microsocial categories. Some work has focused on the influence of social networks or social climate in treatment settings. Some efforts attempt to identify relationships between macrosystemic living conditions and therapy outcome (Avissar, 2016). The advantages of Bronfenbrenner's perspective include a focus on complicated human environments, as well as indirect means of affecting different levels of environments and the individuals who live in them.

At a micro level of analysis, the therapist-client relationship represents one of the most important categories in psychotherapy. The quantifiable importance of this relationship in terms of therapy outcome is debatable. Many meta-analyses confirm its influence regardless of psychotherapeutic treatment orientation (e.g. Flückiger, Del Re, Wampold & Horvath, 2018). At the same time, systematic training and supervision of psychotherapists can lead to increases in efficacy (e.g., Smith-Hansen, 2016). This way, therapeutic skills (e.g. to cope with therapeutic rupture or the therapist's own emotional responses) can be addressed, and therapeutic results can be enhanced (Watkins, 2011).

On a mesosystem level, more complex interactions and connections can be utilized (Lawlor & Neal, 2016). For instance, family-based services or social network interventions have shown significant effects in several meta-analyses and reviews (e.g. Barker & Pistrang, 2002; Meis et al., 2013). The influence of social networks or social support on therapy outcome, for instance, has been empirically researched. Contrary to the expectations of psychotherapy researchers, these effects are relatively small (Park, Cuijpers, van Straten & Reynolds, 2014; Roehrle & Strouse, 2008). In comparison, meta-analyses show peer support to be highly effective. These publications usually claim that peer support is not inferior to professional support (e.g. Bryan & Arkowit, 2015). Peer support and self-help broaden the spectrum of possibilities in psychotherapy quantitatively and qualitatively. Curricula of training programs have already been developed to utilize these elements, involving peer-support experienced in psychiatric and psychological treatment. Studies show that not only patients but also peers gained knowledge of wellness, empowerment, empathy, self-efficacy, and collective influence through these curricula.

Thus, peer supports tend to increase knowledge and the development of positive emotions in clients. They also seemed to reduce hospitalization of the sustained patients. Finally, peer supports also gained occupational advantages for themselves (Chinman et al., 2014; Gillard & Holley, 2014; Hegedues, Seidel & Steinauer, 2016; Mahlke, Kraemer, Becker & Bock, 2014; Mahlke, Priebe, Heumann & Bock, 2017; Sledge et al., 2011; Utschakowski, 2008).

On the exo system level, organizations utilize the concept of social climates therapeutically. The social climates of treatment institutions (including self-help groups) can be analyzed using different dimensions, which are also useful for quality assessment. These dimensions include individual development opportunities, as well as structural attributes such as transparency, scope of design, socio-emotional quality of interaction, or physical frameworks for guidance and interaction in treatment institutions (Tonkin, 2016). These attributes can predict therapeutic efficacy. For instance, discrepancy between patient and therapist responses can be helpful for development of organizational change in treatment settings (e.g., Curtin & Eacho, 2012; Doyle, Quayle & Newman, 2017). Without any explicit recourse to social climate concepts, Taylor et al. (2009) found setting attributes that positively influence therapy outcome: closeness to community, or a low staff to client ratio; and on lower system levels also a positive therapist-client relationship, high flexibility in offered therapy, maximum confidentiality, just to name a few. These factors may reflect the characteristics of an institution.

An example of a concept based more on communal ideology is *sense of community*. Sense of community goes beyond organizations and attachment structures in social networks The concept describes the communal quality of life as a socially, culturally, and politically integrated factor by representing the social, political and cultural world from the subjective view of citizens (Sarason, 1974; Long & Perkins, 2003; McMillan & Chavis, 1986; McNamara, Stevenson & Muldoon, 2013). *Sense of community* is frequently measured by social-emotional connections, mutual concerns and values, need fulfillment, influence, and local identification. In a meta-analysis, *sense of community* is closely related to different forms of participation (Talò, Mannarini & Rochira, 2014). More recently, *sense of community* has also been used as a category to describe the quality of living circumstances of people with severe mental illness in protective housing programs. Patients in these programs developed a sense of community connected to the quality of tolerant neighborly relationships (Townley & Kloos, 2011). From this evidence, we may infer that designing optimal treatment conditions also includes fostering neighborly relationships, which helps strengthen a sense of community as a prerequisite of participation, indicating also mental health. These allow acceptance, tolerance, and cooperativeness in the living environments of clients. Several studies indicate that such influence is possible (e.g. Andrade, Ferreira Filha, Toledo Vianna, Silva & Costa, 2012; Jason, Stevens & Light, 2016; O'Connor, 2013). Some larger studies show that the sense of community construct may also illustrate protective factors and mental health needs of adolescents in communities (Baiden, den Dunnen, Arku & Mkandawire, 2014; Garcia-Reid, Peterson, Reid & Peterson, 2013; Kitchen, Williams & Chowhan, 2012; Townley & Kloos, 2009).

The effects of psychotherapies are not only connected with a collective understanding of living conditions, like the sense of community, but are also connected to the question as to whether the acquisition of reflexive processes and the communication of collective values in a society lead to meaningful outcomes. This way, the value orientations of client and therapist can be balanced more effectively, on a macro system level, with collectively meaningful awareness processes as a basis for developing humane living conditions (Kelly & Strupp, 1992, Kirschenbaum, 2013). This type of societally based reflective process may help destigmatize

mental health disorders, increase collective resistance potentials, help to take action for social justice goals, and create societal codetermination opportunities (Kagan, Burton, Duckett, Lawthom & Siddiquee, 2011; Munger, MacLeod & Loomis, 2016). But common socio-cultural goals are only one feature of humane living conditions. Other properties such as the quality of life, education, income, etc., are also very important. In relation to that, it remains an open question as to whether these features are also essential for psychotherapeutic effects in high- or low-developed countries. On the other side, the influence of socioeconomic status of mentally ill people on psychotherapeutic effects seem to be well researched.

2.2. The Ecological Context of Psychotherapy

A second idea of a possible contextualization of psychotherapy is associated with the ecological metaphor by Kelly (1986), which is widely known in community psychology. This metaphor conceptualizes psychosocially important environments as resembling habitats. It can be seen as a concept analogous to a biological perspective. These habitats represent historically grown, interdependent distribution systems. Their make-up defines the type of distribution of resources in social systems. As such, they define standards about placement of people, skills, roles, events, and physical attributes, so that individual as well as collectively meaningful needs can be satisfied (e.g. Trickett, 2009).

The demand for resource orientation in the context of the ecological metaphor has already been addressed by psychotherapy (Flückiger, Wuesten, Zinbarg & Wambold, 2010). Various assessments and interventions were developed and are being used to empirically predict disorders and treatments. Limitations remain. The influence of attributes such as quality of life in the place of residence and employment remain largely untouched. Superior and indirect influences, as well as individually and collectively meaningful resources, are not being considered. An example is the meta-analytical knowledge of effects of behavioral therapy on quality of life of patients. These show medium effect sizes for love life, employment, and recreation (Hofman, Wu & Boettcher, 2014).

Resources that emphasize these resources are described as social capital, opening ways for the acquisition and realization of capabilities, and giving possibilities for recovery. Features of social capital are, for instance, objective accessibility to networks, organizations, and offers of assistance. But they can also be subjectively perceived as values, norms, responsibilities, confidence, and altruism. Results show that social capital can predict the prevention of developing disorders (Ehsan & DeSilva, 2015). For instance, there is evidence that the process of people with alcohol use disorders engaging in self-help groups increased the participants' quality of life and also strengthened social capital in the community (Folgheraiter & Pasin, 2009). It would be advisable that the world of psychotherapy not only analyzes and strengthens the usual resources, but also involves dimensions of social capital (Engbers, Thompson & Slaper, 2016).

While social capital emphasizes the accessibility of existing resources, the following category, that is, capability, defines possibilities for environments and individuals to develop socially, economically, ecologically, politically, and culturally (Munger et al., 2016). This capability approach focuses more on the equitable organization of life than on the distribution of goods. In reference to Nussbaum (2011), central themes of this concept are the emotional, cognitive, and meaningful capacities of individuals, and the confidence-inducing potentials of society (Sacchetto et al., 2016). Attributes of this kind are also appropriately used to predict

psychological health. Limited opportunities to connect with others, and to appreciate and respect social environments, as well as impaired daily routines or limited creativity, showed as predictors for poor psychological health. When those contexts were paired with limited social networks and socioeconomic disadvantages, predictions could be made for psychotic disorders (Simon et al, 2013). Based on these findings, psychotherapeutic action can go beyond imparting social-interactive and emotionally regulating competencies, because it can also ask which individual and contextual conditions are existent or needed in a person's life in order to develop personal potentials. This idea fits well into the behavioral plan analysis in psychotherapy and the analysis of objective opportunity for action (analysis of space of action).

The recovery approach has some structural similarities to the capability concept. Recovery approach is rooted in the psychiatric field. This approach focuses on individual and contextual opportunities to promote health for people with psychological disorders. Interventions of the recovery approach promote individually adapted basic security, and stand for a long-term social protection of clients (Frost et al., 2017). This approach builds on social psychiatric ideas of person-oriented treatment and is associated with integrated views of psychotherapy (Reisner, 2005). The concrete need for helping clients becomes the central focus, rather than the structural, social justice, and supply requirements of social services. The goal of the recovery approach is to restore social roles. This is to be accomplished via the strengthening of positive self-perception, social connectedness, wellness, hope, meaningfulness, as well as through day to day opportunities (Frost et al., 2017). At the same time, there are attempts to decrease the stigma of mental health disorders. Recovery approaches have become more prevalent in psychotherapy. In a study by Jones et al. (2015), people with bipolar disorder were supported specifically according to the recovery approach. They were compared to another sample who were treated with psychiatric medication management. Participants of the recovery condition were encouraged to focus on individual and collective treatment goals as well as actions. They were also encouraged to change stigmatizing language. The results showed better and longer lasting improvements for the experimental group. O'Mara-Eves et al. (2013) analyzed 105 studies and showed effect sizes of Cohen's d=.33, indicating that community psychological studies as described above can assist in promoting health behavior. At the same time, participant self-efficacy increased (20 studies, d=.44). The meta-analysis was replicated on a broader database and showed the same results (O'Mara-Eves et al., 2015). However, when considering the involved costs of such an approach, results are not conclusive.

The equivalent of community psychologically meaningful systems which are near to the recovery concept and the capability approach can be found in the resources of niches as it were described by Kelly (1986). Niches are available for individuals or social groups, and can be utilized through adaptation processes. There are similarities between Kelly's idea of social niches and ecological psychotherapy by Willi (1999). Promoting change in mental health disorders is facilitated in this type of therapy by revealing old niches and their development-inhibiting qualities, and easing transitions to new niches (Willi, Frei & Guenther, 2000). The therapist is encouraged to detect livability for the client by investigating current resistances, and to strengthen resources and potentials.

3. The World of Values in a Community Psychology Oriented Psychotherapy

Regardless of the nature of the contextual organization, community-psychology-oriented psychotherapy has to address basic values in human life. The main values in community psychology are social justice, freedom to live in diversity, in Inclusion, and with reflexivity and emancipation (Kagan, et. al., 2011; Nelson & Prilleltensky, 2010; Orford, 2008). Based on these values, the likelihood of developing a mental illness as well as receiving treatment for it should be equally distributed for every citizen regardless of social and cultural background. In this sense community psychology oriented interventions are some kind of macro system feature or an overarching determination. Stabb and Reimers (2013) reference in this context competence benchmarks by the APA (American Psychological Association) as a frame of integration of best practices in working with poor and working class people. Only with these competences can psychotherapists respond appropriately to social, economic, and spiritual features of their clients. Recommendations include case-oriented rather than upper-class-oriented treatment routines. Studies show that the choice of emphasis in therapy is strongly influenced by the treatment provider's sociopolitical consciousness, as well as to the degree to which the provider is disposed to advocate for underserved groups. The extent to which the training in these competencies will influence treatment outcome remains unanswered (Chung & Bemak, 2012; Cutts, 2013, Thatcher & Manktelow, 2007; Wakefield, 1988a, b).

Behavior psychotherapy has addressed living circumstances for lower socioeconomic statuses since its earlier stages, and recommended using peer support besides more standard practices, such as role play and model learning (Goldstein, 1973). However, the notion persisted that behavior psychotherapy does not have to adjust to specific groups due to learning processes being universal processes. This notion seemed to include a form of acceptance that lower socioeconomic groups may be excluded and suffer from more severe disorders and may therefore achieve less successful therapy outcomes. In contrast, authors with a psychodynamic perspective have emphasized that the socioeconomic level of treatment providers is important for therapy success (Fontana, Dowds & Eisenstadt, 1980). Empirical support to determine whether this type of closeness to living conditions yields higher results than does less socioeconomically oriented treatments remains unclear. The same seems true for attempts to enhance implementation processes of therapy interventions through specific trainings (Stuart, Schultz & Ashen, 2018). There are advanced attempts to increase psychotherapists' ecological and societal consciousness, where psychotherapists are supposed to adjust to client expectations, increase their role as advocate, and cope with their own social role reflectively (most recent, Ali & Lees, 2013). Interventions like these try to reduce the exclusion of lower social positions.

Newer studies of behavior psychotherapies with disadvantaged lower socioeconomic groups yield mixed results. In comparison with control groups, experimental groups appear to respond to psychotherapy much more than (Voss Horrell, 2008). Levy and O'Hara (2010) qualitatively analyzed 21 studies that examined depressed females of low socioeconomic status. They found that treatments were especially effective when they lead to destigmatization and increased empowerment, and when they were near to people's living conditions, and provided social support in group treatments as well as in outreach services (e.g., home visits by therapists). While empirical knowledge of socioeconomic level competencies is still limited, results of culturally competent care are unambiguous. Meta-analyses show that culturally informed care yields higher effect sizes than do universal approaches. Griner and Smith (2006) showed an

effect of d=.45 over 76 studies for culturally competent interventions. These studies frequently utilized therapists who spoke the language of participants, were familiar with cultural norms, and exercised ambiguity tolerance.

Besides the focus on specific cultural and social living conditions, community psychology also focuses on the possibilities for individuals and collectives to engage in emancipatory processes and take charge of their own future. These processes of empowerment are intended to allow for creating better working conditions, have needs met more consistently, increase self-efficacy, develop hope, focus on resources, and decrease stigma. They also increase the collective sense of control and impact, leading to increased support, engagement, and increased exertion of influence in the community. Several studies illustrate the advantages of empowerment processes in the context of psychological disorders and psychotherapy. There are epidemiological connections between the degree of empowerment and the severity of psychological impairment (Krajewski, Burazeri & Brand, 2013). In trainings for parents whose children suffer from mental health diagnoses, empowerment leads to positive changes in the stress level of parents. Similar effects were reported for children (Bode, George, Weist, Lever & Youngstrom, 2016). Empowerment processes were an important predictor for adults with mental health disorders in relation to their recovery and to lower relapse rates (Fitzsimons & Fuller, 2002).

Newer studies are showing that the quality of help by professionals can be increased by using empowerment processes (Engström, Westerberg Jacobson & Mårtensson, 2015). However, in the context of psychotherapy, this concept is rarely empirically utilized. For instance, it appears in case studies that focus on the treatment of adolescents of color, where the experience of power appeared to increase in the treatment sample (Querimit & Conner, 2003). Other authors focus on empowerment as empirically justifiable strategies for internet treatment of eating disorders (Aardoom, Dingemans, Boogard & Van Furth, 2014). Another example of the effectiveness of empowerment is the training of peer support, as discussed above.

Community psychology values can influence not only psychotherapeutic processes and effects, but also preventive interventions. Prevention and mental health promotion are not only a central characteristic, especially for setting-oriented approaches in community psychology, but also a necessary part of psychotherapy, included in curative helping but also as a parallel process in which keeping someone healthy is at least important as healing the victims and patients.

4. Prevention Oriented Psychotherapy

Initially, one may believe that prevention must precede psychological disorders or psychological treatment interventions. But when we evaluate this matter more closely, it becomes apparent that, in many cases, prevention happens alongside psychotherapy. Initially, there is a high number of comorbid symptoms that do not yet qualify for a diagnosis. Clients with incisive diagnoses are two to five times more likely to become depressed or develop a generalized anxiety disorder. These subliminal disorders are usually treated alongside the principal diagnosis (Cuijpers, van Straten & Smit, 2007). Central themes of prevention include depression, suicidal tendencies, anxiety disorders, eating disorders, externalizing behavioral disorders, substance use disorders, and schizophrenia. Furthermore, mental health disorders are frequently accompanied by stressors for which generic psychotherapeutic helping skills are not

specific enough to cope with special stressors. (e.g. Lenze, Cyranowski, Thompson, Anderson & Frank, 2008). Many of these programs, such as coping with unemployment, loneliness, losses, threats due to violence, marital problems and care of family members or mentally ill parents have been developed and even meta-analytically evaluated (most recently Christiansen, Evert & Roehrle, 2018).

In addition to universal forms of prevention, there are those that focus mostly on wellness. Carried by ideas of Positive Psychology, both psychotherapy and prevention efforts focus here mostly on individual goals. Interventions of this kind include acceptance and commitment, mindfulness, gratitude, and reminiscence therapy. These interventions are also well evaluated in psychotherapy and prevention research (e.g. Flückiger, Wuesten, Zinbarg & Wambold, 2010; Sharma, Sharma & Sharma, 2017). Almost all approaches of positive psychology encourage an accepting stance for clients. This is quite the opposite of procedures in community psychology, which focus more on empowerment processes and on emphasizing collective social well-being in the sense of social cohesiveness, attainment, integration, and acceptance (Keyes, 1998; Wilkinson, 1979).

However, there are also prevention studies taking place on different contextual levels. On the micro system level, some studies focus on fostering early mother-child relationships or parent child relationships, as well as relationships of couples and family systems. On a meso system level, there exist programs for drug prevention and youth problems. Furthermore, on the exo system level of organizations (e.g. schools) or communities, various programs were developed. For instance, epidemiological data is utilized to develop and offer specific and locally relevant programs. An especially widely known project is "The Community that Cares" which has yielded significant results in experimental studies (Jenson & Bender, 2014). In this program, community and problem-specific plans of action are gathered and assembled. Even on the macro system level, there are meaningful approaches to create social justice and exert influence (Hage & Kenny, 2009; Leijten, Raaijmakers, Orobio de Castro & Matthys, 2013). Successful efforts with basic security benefits and financial support for families in poverty have decreased the number of mental health disorders (Costello, Erkanli, Copeland & Angold, 2010; Forget, 2011).

5. Perspectives

Finally, the question remains as to why psychotherapists do not use the possibilities of community psychology, given the multitude of options. There may be several reasons for this shortcoming. The most important reason has to do with the fact that reductionist views, which are not acceptable in the view of community psychologist, cannot be accepted as simplified and value minimized world of psychotherapy. In addition, the central task of community psychology is determined by an unrealistic, value-restrained, but also legislated separation of prevention and psychotherapy. In many cases, there is also a lack of training for psychotherapists, which includes both the development of healing and preventive skills.

The healing tasks of psychotherapy are limited to the simplifying reductionisms of the concepts. On one hand, psychotherapist do not foresee the complex influence of social systems on individual events like mental disorders or well-being. The curative tasks are minimized in relationships like alliances between patient and psychotherapist, therapeutic groups, or families. But all of these micro systems are influenced by other environmental levels. For example, the

world of labor has spill-over effects on social networks, family, or the working situation of the psychotherapist, and ultimately, on the well-being of patients. Healing tasks cannot be minimized in changing unconscious process, irrational beliefs, or self-actualizing tendencies; they also have to do with necessary changes on the micro-, exo-, and macro system level. In the Generic Model of Psychotherapy proposed by Orlinsky (2009), this already appears. But changing the pathological influences of different system levels are nevertheless not in the habitual hierarchies of researching and practicing psychotherapists. These levels cannot be reached alone by changing feelings, cognitions, self-discrepancies, and the mentalization of inner and outer conflicts. The negative influences need to be defeated by the collective action of a supporting psychotherapist, other helpers, and empowered victims or experienced patients. The fulfillment of needs, which is basic in psychotherapy, has to specify also the possibilities in the living circumstances of patients. Research has pointed out that at least social position, inequality, unemployment, supporting social contexts in networks, neighborhoods producing a sense of community, and organizational features have a tremendous relevance in producing mental health effect also in the context of psychotherapeutic institutions. Social resources, conditions in the sense of capability or recovery, are already sought by psychotherapy on different system levels or niches in life circumstances.

In research as well as in the practice of psychotherapy, this means that the influence of context variables has to be part of reflective thinking, diagnosis, intervention, and evaluation. Nearly all psychotherapeutic schools mentioned above have the potential to realize this recommendation. In the psychodynamic approach, mentalization of possible influences coming from context variables can be defined. Understanding context influences can be followed by action, also in collective ways, in which the principle of reality may solve problems on complex system levels, and also by accepting values as leading goals in different environment and niches (Koh & Twemlow, 2018). Humanistic-oriented psychotherapies can also work out basic needs and their fulfillment. The phenomenological field of experience enables an understanding of capabilities and growth. Cognitive behavior therapy is able to incorporate different stimuli as proximal and distal environmental cues situated on different system levels. The cognitive way of understanding life situations can be enriched not only by schemata, plan, and goals, but also by complex naïve theories about contextual influences on the world of patients. Only specified psychotherapeutic approaches like we find in the perspective of positive psychology or in techniques of acceptance and commitment therapy open up a way to basic community psychology values like social equality or the acceptance of social diversity. Context-oriented psychotherapy should at least be able to name the negative parts in the outer world and to give significance to the different values of patient, psychotherapist, and the micro systems. Understanding possible influences for the minimization of psychotherapy involves realizing how the frame of legislation for psychotherapy individualizes the problems of patients.

The individualization of psychotherapy is not only caused by legislation, but has also to do with the missing link between community psychology and psychotherapy education. There are deficits in many countries regarding training opportunities for community psychological treatments not only in the context of psychotherapeutic education (Constantino, Morrison, Coyne & Howard, 2017). Exceptions are partially the USA, Australia, and Europe (England, Norway, Portugal, Italy; Roehrle, Akhurst, Lawthorn, Arcidiacono, & Standing Committee on Community Psychology, in preparation).

The lag of community psychology influences also means that a very important part of psychotherapy is missing, namely the incorporation of prevention. The education in

psychotherapy is not defined enough by prevention topics. In addition, the prevention abstinence is sustained by missing legislation which recommends from psychotherapist to be able to offer preventive services. In many countries, the education of psychotherapist is restrained to school-specific healing-oriented competences. Overlooked is the fact that, in many cases, patients have subliminal disorders or suffer from life events that require specific forms of helping (e.g. being children of mentally ill parents, suffering from loneliness, the loss of loved ones, from unemployment, divorce, violent neighborhoods or schools, etc.). However, for these occasions the disturbance-specific competencies are not sufficient to cope with the diversity of accompanying problems and risks. In addition, the legislation of preventive intervention is rare worldwide and therefore does not reach the necessary incorporation of prevention in psychotherapy (e.g. France, Germany, Norway, Switzerland). Only with a clear and legislated community psychology perspective of psychotherapy, and a complex view of the world, value-oriented changes, and preventive interventions are possible.

References

Aardoom, J.J., Dingemans, A.E., Boogaard, L.H., & Van Furth, E.F. (2014). Internet and patient empowerment in individuals with symptoms of an eating disorder: A cross-sectional investigation of a pro-recovery focused e-community. *Eating Behaviors, 15,* 350–356.

Adler, A. (1938). *Social interest: A challenge to mankind.* London: Faber and Faber.

Ali, A., & Lees, K.E. (2013). The therapist as advocate: Anti-oppression advocacy in psychological practice. *Journal of Clinical Psychology: In Session, 69*(2), 162–171.

Altman, N. (2009). *The analyst in the city: Race, class, and culture through a psychoanalytic lens*. New York: Analytic Press.

Altus, D.E., & Morris, E.K. (2009). B. F. Skinner's utopian vision: Behind and beyond Walden Two. *Behavior Analysis, 32*(2), 319-335.

Andrade, F.B., Ferreira Filha, M., Toledo Vianna, R.P., Silva, A.O., & Costa, I.C.C. (2012). Evaluation of participant satisfaction with community therapy: A mental health strategy in primary care. *Psychiatry Quarterly, 83,* 325–334.

Argentino, P. (2001). Gestalt psychotherapy as community therapy. *Therapeutic Communities, 22*(2), 85-98.

Avissar, N. (2016). *Psychotherapy, society, and politics: From theory to practice*. New York: Palgrave Macmillan.

Baiden, P., den Dunnen, W., Arku, G., & Mkandawire, P. (2014). The role of sense of community belonging on unmet health care needs in Ontario, Canada: Findings from the 2012 Canadian community health survey. *Journal of Public Health, 22*(5), 467–478.

Bandura, A. (1986). *Social foundations of thought and action: a social cognitive theory*. 1986, Englewood Cliffs, N.J.: Prentice-Hall

Barker, C., & Pistrang, N. (2002). Psychotherapy and social support: Integrating research on psychological helping. *Clinical Psychology Review, 22* (3), 361–379.

Baruch, G., & Fearon, P. (2002). The evaluation of mental health outcome at a community-based psychodynamic psychotherapy service for young people: A 12-month follow-up based on self-report data. *Psychology and Psychotherapy: Theory, Research and Practice, 75*(3), 261-278.

Bode, A.A., George, M.W., Weist, M.D., Lever, N., & Youngstrom, E.A. (2016). The impact of

parent empowerment in children's mental health services on parenting stress. *Journal of Child and Family Studies, 25,* 3044–3055.

Bronfenbrenner, U. (1979). *The ecology of human development. Experiments by nature and design.* Cambridge: Harvard University Press.

Bryan, A.E.B., & Arkowit, H. (2015). Meta-analysis of the effects of peer-administered psychosocial interventions on symptoms of depression. *American Journal of Community Psychology, 55*(3), 455–471.

Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S.S., Swift, A., & Delphin-Rittmon, M.E. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services*, *65,* 429–441.

Christiansen, H., Ebert, D., & Roehrle, B. (2018). *Prävention und Gesundheitsförderung Bd. VI. Perspektiven. (Prevention and health promotion Vol. VI. Perspectives*). Tuebingen: DGVT.

Chung, R.C.-Y., & Bemak, F.P. (2012). *Social justice counseling: The next steps beyond multiculturalism.* London: Sage.

Constantino, M.J., Morrison, N.R., Coyne, A.E., & Howard, T. (2017). Exploring therapeutic alliance training in clinical and counseling psychology graduate programs. *Training and Education in Professional Psychology, 11*(4), 219–226.

Costello, E.J., Erkanli, A., Copeland, W., & Angold, A. (2010). Association of family income supplements in adolescence with development of psychiatric and substance use disorders in adulthood among an American Indian population. *Journal of the American Medical Association, 303*(19), 1954–1960.

Cuijpers, P., van Straten, F., & Smit, A. (2007). Psychological treatments of subthreshold depression: A meta-analytic review. *Acta Psychiatrica Scandinavica, 115* (6), 434–441.

Curtin, K.A., & Eacho, C. (2012). Dimensions of social climate as predictors of satisfaction with multifamily therapy groups for families of students with emotional and behavioral disorders. *Group, 36*(4), 283–301.

Cutts, L.A. (2013). Considering a social justice agenda for counselling psychology in the UK. *Counselling Psychology Review, 28*(2), 8–15.

Doyle, P., Quayle, E., & Newman, E. (2017) Social climate in forensic mental health settings: A systematic review of qualitative studies. *Aggression and Violent Behavior, 36*, 118-136

Ehsan, A.M., & DeSilva, M.J. (2015). Social capital and common mental disorder: a systematic review. *Journal of Epidemiological Community Health, 69,* 1021–1028.

Engbers, T.A., Thompson, M.F., & Slaper, T.F. (2016). *Theory and measurement in social capital research. Social Indicator Research, 132*(2), 537-558. DOI 10.1007/s11205-016-1299-0

Engström, M., Westerberg Jacobson, J., & Mårtensson, G. (2015). Staff assessment of structural empowerment and ability to work according to evidence-based practice in mental health care. *Journal of Nursing Management, 23*(6), 765–774.

Epping, J., Muschik, D., & Geyer, S. (2017). Social inequalities in the utilization of outpatient psychotherapy: analyses of registry data from German statutory health insurance. *International Journal for Equity in Health, 16*, 147-155.

Fine, P. (2007). Psychodynamic psychiatry in community settings. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 35*(3), 431-441.

Finegan, M., Firth, N., Wojnarowski, C., & Delgadillo, J. (2017). Associations between socioeconomic status and psychological therapy outcomes: A systematic review and meta-

analysis. *Depression and Anxiety, 35*, 560–573.
Fitzsimons, S., & Fuller, R. (2002). Empowerment and its implications for clinical practice in mental health: A review. *Journal of Mental Health, 11*(5), 481–499.
Flückiger, C., Del Re, A.C., Wampold, B.E., & Horvath, A.O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316-340.
Folgheraiter, F., & Pasin, A. (2009). Self-help groups and social capital: New directions in welfare policies? *Social Work Education, 28*(3), 253–267.
Flückiger, C., Wüsten, G., Zinbarg, R. E. & Wampold, B. E. (2010). Resource activation – Working with the patient strengths. Göttingen, Germany: Hogrefe.
Fontana, A., Dowds, B.N., & Eisenstadt, R.L. (1980). Social class and suitability for psychodynamic psychotherapy: A causal model. *Journal of Nervous and Mental Disease, 168* (11), 658–665.
Forget, E.L. (2011). *The town without poverty. Using health administration data to revisit outcomes of a Canadian guaranteed annual income field experiment.* University of Manitoba. Retrieved from http://public.econ.duke.edu/~erw/197/forget-cea%20(2).pdf [29.11.16].
Frost, B.G., Tirupati, S., Johnston, S., Turrell, M., Lewin, T.J., Sly, K.A., & Conrad, A. (2017). An integrated recovery-oriented model (IRM) for mental health services: evolution and challenges. *BMC Psychiatry, 17*(1).
Fuller, R.C. (1982). Carl Rogers, religion, and the role of psychology in the American culture. *Journal of Humanistic Psychology, 22*(4), 21-32.
Garcia-Reid, P., Peterson, C.H., Reid, R.J., & Peterson, A. (2013). The protective effects of sense of community, multigroup ethnic identity, and self-esteem against internalizing problems among dominican youth: Implications for social workers. *Social Work in Mental Health, 11*(3), 199–222.
Gendlin, E.T. (1968). Psychotherapy and community psychology. *Psychotherapy: Theory, Research and Practice, 5* (2), 67–72. Retrieved from http://www.focusing.org/gendlin/docs/gol_2135.html [23.11.16].
Gibbons, M.B.C., Rothbard, A., Farris, K D., Wiltsey, S., Thompson, S.M., Scott, K., Heintz, L.E., Gallop, R., & Crits-Christoph, P. (2011). Changes in psychotherapy utilization among consumers of services for major depressive disorder in the community mental health system. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(6), 495-503.
Gillard, S., & Holley, J. (2014). Peer workers in mental health services: Literature overview. *Advances in Psychiatric Treatment, 20*, 286–292.
Goldstein, A.P. (1973). *Structured learning therapy: Toward a psychotherapy fort the poor.* Oxford: Academic press.
Goodman, L. A., Pugach, M., Skolnik, A., & Smith, L. (2013). Poverty and mental health practice: Within and beyond the 50-minute hour. *Journal of Clinical Psychology: In Session, 69*(2), 182–190.
Griner, D., & Smith, T.B. (2006). Cultural adapted mental interventions: A meta-analytic review. *Psychotherapy Theory, research, and Practice, Training, 43*(4), 531–548.
Hage, S.M, & Kenny, M.E. (2009). Promoting a social justice approach to prevention: Future directions for training, practice, and research. *Journal of Primary Prevention, 30,* 75–87.
Hegedues, A., Seidel, E., & Steinauer, R. (2016). Participants' employment status and experiences in the year after the Experienced Involvement training. *International Journal of Social Psychiatry, 62*(3), 214-220.

Hinshelwood, R.D. (2005). The individual and the influence of social settings: A psychoanalytic perspective on the interaction of the individual and society. *British Journal of Psychotherapy, 22*(2), 155-166.

Hofmann, S.G., Wu, J.Q. & Boettcher, H. (2014). Effect of cognitive-behavioral therapy for anxiety disorders on quality of life: A meta-analysis. *Journal of Consulting and Clinical Psychology, 82*(3), 375-91. doi: 10.1037/a0035491.

Jason, L.A., Stevens, E., & Light, J.M. (2016). The relationship of sense of community and trust to hope. *Journal of Community Psychology, 44*(3), 334–341.

Jenson, J.M., & Bender, K.A. (2014). *Preventing child and adolescent problem behavior. Evidence-based strategies in schools, families, and communities.* New York: Oxford University Press.

Jones, S.H., Smith, G., Mulligan, L.D., Lobban, F., Law, H., Dunn, G., Welford, M., Kelly, J., Mulligan, J., & Morrisoon, A.P. (2015). Recovery focused cognitive–behavioural therapy for recent-onset bipolar disorder: randomized controlled pilot trial. *The British Journal of Psychiatry, 206,* 58–66.

Kagan, C.M., Burton, M., Duckett, P.S., Lawthom, R., & Siddiquee, A. (2011). *Critical community psychology.* New York: Wiley-Blackwell.

Kelly, J.G. (1986). An ecological paradigm: Defining mental health consultation as a preventive service. *Prevention in Human Services, 4,* 1–36.

Kelly, T.A., & Strupp, H.H. (1992). Patient and therapist values in psychotherapy: Perceived changes, assimilation, similarity, and outcome. *Journal of Consulting and Clinical Psychology, 60*(1), 34–40.

Keyes, C.L M. (1998). Social well-being. *Social Psychology Quarterly, 61*(2), 121–140.

Kim, S. & Cardemil, E. (2012). Effective psychotherapy with low-income clients: The importance of attending to social class. *Journal of Contemporary Psychotherapy, 42,* 27–35.

King, R.A., & Shelley, C.A. (2008). Community feeling and social interest: Adlerian parallels, synergy and differences with the field of community psychology. *Journal of Community and Applied Social Psychology, 18,* 96–107.

Kirschenbaum, H. (2013). *Values clarification in counseling and psychotherapy: practical strategies for individual and group settings.* New York: Oxford University Press.

Kitchen, P., Williams, A., & Chowhan, J. (2012). Sense of community belonging and health in Canada: A regional analysis. *Social Indicators Research, 107*(1), 103–126.

Koh, E., & Twemlow, S. (2016). Towards a psychoanalytic concept of community (II): Relevant psychoanalytic principles. *International Journal of Applied Psychoanalytic Studies, 13*(2), 124–141.

Koh, E., & Twemlow, S. (2018). Towards a psychoanalytic concept of community (IV): The well-functioning community. *International Journal of Applied Psychoanalytic Studies, 15*, 5–15.

Krajewski, C., Burazeri, G., & Brand, H. (2013). Self-stigma, perceived discrimination and empowerment among people with a mental illness in six countries: Pan European stigma study. *Psychiatry Research, 210*(3), 1136–1146.

Lawlor, J.A., & Neal, Z.P. (2016). Networked community change: Understanding community systems change through the lens of social network analysis. *American Journal of Community Psychology, 57*(3–4), 426–436.

Leijten, P., Raaijmakers, M.A.J., Orobio de Castro, B., & Matthys, W. (2013). Does

socioeconomic status matter? A meta-analysis on parent training effectiveness for disruptive child behavior. *Journal of Clinical Child, & Adolescent Psychology, 42*(3), 384–392.

Lenze, S.N., Cyranowski, J.M., Thompson, W.K., Anderson, B., & Frank, E. (2008). The cumulative impact of non-severe life events predicts depression recurrence during maintenance treatment with interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 76*(6), 979–987.

Levy, L.B., & O'Hara, M.W. (2010). Psychotherapeutic interventions for depressed, low income women: A review of the literature. *Clinical Psychology Review, 30,* 934–950.

Liang, B., Tummala-Narra, P., & West, J. (2011). Revisiting community work from a psychodynamic perspective. *Professional Psychology: Research and Practice, 42*(5), 398-404.

Long, D. A., & Perkins, D. D. (2003). Confirmatory factor analysis of the sense of community index and development of a brief SCI. *Journal of Community Psychology, 31,* 279–296.

Mahlke, C.I., Kraemer, U.M., Becker, T., & Bock, T. (2014). Peer support in mental health services. *Current Opinion in Psychiatry, 27*, 276–281.

Mahlke, C.I., Priebe, S., Heumann, K., & Bock, T. (2017). Effectiveness of one-to-one peer support for patients with severe mental illness – a randomized controlled trial. *European Psychiatry, 42*, 103-110.

Maurer, R., & Gaffiney, S. (2005). Gestalt approaches with organizations and large systems. In A. Woldt, & S. Toman (Eds), *Gestalt therapy: History, theory, and practice* (pp 237-256). Thousand Oaks: Sage.

McMillan, D.W., & Chavis, D.M. (1986). Sense of community: A definition and theory. *Journal of Community Psychology, 14*(1), 6–23.

McNamara, N., Stevenson, C., & Muldoon, O.T. (2013). Community identity as resource and context: A mixed method investigation of coping and collective action in a disadvantaged community. *European Journal of Social Psychology, 43,* 393–403.

Meis, L.A., Griffin, J.M., Greer, N., Jensen, A.C., MacDonald, R., Carlyle, M., Rutsk, I., & Wilt, T.J. (2013). Couple and family involvement in adult mental health treatment: A systematic review. *Clinical Psychology Review, 33,* 275–286.

Montery Declaration of Critical Community Psychology (2011). (Retrieved from http://www.scra27.org/files/4014/0612/7815/MONTEREY_DECLARATION_OF_CRITICAL_COMMUNITY_PSYCHOLOGY.pdf [15.11.16]).

Munger, F., MacLeod, T., & Loomis, C. (2016). Social change: Toward an informed and critical understanding of social justice and the capabilities approach in community psychology. *American Journal of Community Psychology, 57,* 171–180.

Muntaner, C., Ng, E., Vanroelen, C., Christ, S., & Eaton, W.W. (2013). Social stratification, social closure, and social class as determinants of mental health disparities. In C.S. Aneshensel, J.C. Phelan & A. Bierman (Eds.), *Handbook of the sociology of mental health* (pp. 205-227), 2nd ed. New York: Springer.

Nelson, G., & Prilleltensky, I. (2010). *Community psychology: In pursuit of liberation and well-being.* New York: Palgrave.

Nussbaum, M. (2011). *Creating capabilities. The human development approach*. Cambridge: Belknap Press, Harvard University Press.

O'Connor, B. (2013). From isolation to community: Exploratory study of a sense of community intervention. *Journal of Community Psychology, 41*(8), 973–991.

O'Mara-Eves, A., Brunton, G., McDaid, D., Oliver, S., Kavanagh, J., Jamal, F., & Matosevic, T.

(2013). Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. *Public Health Research, 1*(4), 1-548.
O'Mara-Eves, A., Brunton, G., McDaid, D., Oliver, S., Kavanagh, J., Jamal, F., & Thomas, J. (2015). The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis. *BMC Public Health, 15*, 106-129.
Orford, J. (2008). *Community psychology. Challenges, controversies and emerging consensus*. New York: Wiley.
Orlinsky, D.E., & Howard, K.I. (1987). A generic model of psychotherapy. *Journal of Integrative and Eclective Psychotherapy, 6*(6), 6–36.
Orlinsky, D.E. (2009). The "Generic Model of Psychotherapy" after 25 years: Evolution of a research-based metatheory. *Journal of Psychotherapy Integration, 19*(4), 319-339.
Park, M., Cuijpers, P., van Straten, A., & Reynolds, C.F. (2014). The effects of psychotherapy for adult depression on social support: A meta-analysis. *Cognitive Therapy and Research, 38,* 600–611.
Prendergast, N., & McCauseland, J. (2007). Dialectic behaviour therapy: A 12-month collaborative program in a local community setting. *Behaviour Change, 24*(1), 25-35.
Querimit, D.S., & Conner, L.C. (2003). Empowerment psychotherapy with adolescent females of color. *Journal of Clinical Psychology, 59*(11), 1215–1224.
Reisner, A.D. (2005). The common factor, empirically validated treatments and recovery models of therapeutic change. *The Psychological Record, 55*, 377-399.
Rentfrow, P.J., Jokela, M., & Lamb, M E. (2015). Regional personality differences in Great Britain. *PLoS ONE, 10*(3): e0122245. https://doi.org/10.1371/journal.pone.0122245
Roehrle, B., & Strouse, J. (2008). Influence of social support on success of therapeutic interventions: a meta-analytic review. *Psychotherapy Theory, Research, Practice, Training, 45*(4), 464–476.
Roehrle, B., Akhurst, J., Lawthom, R., Arcidiano, C., & Standing Committee on Community Psychology (in preparation). *Education in community psychology in Europe. Report and outline of european ideas related to basic competencies.*
Sacchetto, B., Aguiar, R., Vargas-Moniz, M., Jorge-Monteiro, M.F., Neves, M. J., Cruz, M.A., Coimbra, J.A., & Ornelas, J. (2016). The capabilities questionnaire for the community mental health context (CQ-CMH): A measure inspired by the capabilities approach and constructed through consumer–researcher collaboration. *Psychiatric Rehabilitation Journal, 39*(1), 55–61.
Santiago, C.D., Kaltman S., & Miranda, J. (2013). Poverty and mental Health: How do low income adults and children fare in psychotherapy? *Journal of Clinical Psychology: In Session, 69*(2), 115–126.
Sarason, S.B. (1974). *The psychological sense of community. Prospects for a community psychology.* San Francisco: Jossey-Bass.
Schneider, K.J. (2015). Rediscovering awe: A new front in humanistic psychology, psychotherapy, and society. In K.J. Schneider, J.F. Pierson & J.F.T. Bugetal (Eds.), *The handbook of humanistic psychology: Theory, research, and practice*,2nd ed. (pp. 73-81). Thousand Oaks: Sage.
Sharma, A., Sharma, S.D., & Sharma, M. (2017). Mental health promotion: A narrative review of emerging trends. *Current Opinion in Psychiatry, 30*(5), 339-345.
Simon, J., Anand, P., Gray, A., Rugkåsa, J., Yeeles, K., & Burns, T. (2013). Operationalising the capability approach for outcome measurement in mental health research. *Social Science and Medicine, 98,* 167–196.

Skinner, B.F. (1978) *Reflections on Behaviorism and Society*. New York: Longman Higher Education.
Sledge, W.H., Lawless, M., Sells, D., Wieland M., O'Connell, M.J., & Davidson, L. (2011). Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatric Services, 62*(5), 541-544.
Smith-Hansen, L. (2016). The therapeutic alliance: From correlational studies to training models. *Journal of Psychotherapy Integration*, *26*(3), 217-229.
Staats, A., & Staats, C K. (1963*). Complex human behavior: A systematic extension of learning principles*. New York: Holt, Rinehart & Winston.
Stabb, S.D., & Reimers, F.A. (2013). Competent poverty training. *Journal of Clinical Psychology: In Session, 69*(2), 172–181.
Stuart, S., Schultz, J., & Ashen, C. (2018). A new community-based model for training in evidence-based psychotherapy practice. *Community Mental Health Journal, 54*, 912–920.
Talò, C., Mannarini, T., & Rochira, A. (2014). Sense of community and community participation: A meta-analytic review. *Social Indicators Research, 117*(1), 1–28.
Taylor, T.L., Killaspy, H., Wright, C., Turton, P., White, S., Kallert, T.W., Schuster, M., Cervilla, J.A., Brangier, P., Raboch, J., Kalisová, L., Onchev G., Dimitrov, H., Mezzina, R., Wolf, K., Wiersma, D., Visser, E., Kiejana, A., Ptetrowski, P., Ploumpidis, D., Gonidakis, F., Caldas-de-Almeida, J., Cardoso, G., & King, M.B (2009). A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems. *BMC Psychiatry, 9,* 55–84. doi:10.1186/1471-244X-9-55.
Thatcher, M., & Manktelow, K. (2007). The cost of individualism. *Counseling Psychology Review, 22*(4), 31-43.
Tonkin, M. (2016). A review of questionnaire measures for assessing the social climate in prisons and forensic psychiatric hospitals. *International Journal of Offender Therapy and Comparative Criminology, 60*(12), 1376–1405.
Townley, G., & Kloos, B. (2009). Development of a measure of sense of community for individuals with serious mental illness residing in community settings. *Journal of Community Psychology, 37*(3), 362–380.
Townley, G., & Kloos, B. (2011). Examining the psychological sense of community for individuals with serious mental illness residing in supported housing environments. *Community Mental Health Journal, 47,* 436–446.
Trickett, E.J. (2009). Community psychology: Individuals and interventions in community context. *Annual Review of Psychology, 60,* 395–419.
Tummala-Narra, P. (2013). Psychoanalytic applications in a diverse society. *Psychoanalytic Psychology, 30*(3), 471-487.
Utschakowski, J. (2008). *Training programme for people with experience in mental health crisis to work as trainer and peer supporter.* Retrieved from http://www.adam-europe.eu/prj/1871/prd/3/1/Curriculum_english%20i.pdf.
Uutela, A. (2010). Economic crisis and mental health. *Current Opinion in Psychiatry, 23*(2), 127–130.
Voss Horrell, S.C. (2008). Effectiveness of cognitive–behavioral therapy with adult ethnic minority clients: A review. *Professional Psychology: Research and Practice, 39*(2), 160–168.
Wachtel, P.L. (2014). *Cyclical psychodynamics and the contextual self*. New York: Routledge
Wakefield, J.C. (1988a). Psychotherapy, distributive justice, and social work. Part 1: Distributive justice as a conceptual framework for social work. *Social Service Review, 62*(2), 187–210.

Wakefield, J.C. (1988b). Psychotherapy, distributive justice, and social work. Part 2: Psychotherapy and the pursuit of justice. *Social Service Review, 62* (3), 353–382.
Watkins, C.E. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *The Clinical Supervisor, 30*, 235–256.
Wilkinson, R. (1979). Social well-being and community. *Journal of the Community Development Society, 10*(1), 5–16.
Willi, J. (1999). *Ecological psychotherapy: Developing by shaping the personal niche*. Goettingen: Hogrefe & Huber Publishers.
Willi, J., Frei, R., & Guenther, E. (2000). Psychotherapy of panic syndrome: Focusing on ecological aspects of relationships. *American Journal of Psychotherapy, 54*(2), 226-242.