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REVIEW ARTICLE

Life History, Clinical Practice and the Training of Psychologists: The Potential Contribution of Psychobiography to Psychology as a "Rigorous Science"

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Abstract

Psychobiography is a qualitative, idiographic research method; it is the explicit and systematic application of psychological theories and models in writing biographies and analyzing the life history, activity and personality of historically significant persons. This method has been used in the investigation of eminent creativity for more than a hundred years from now. It was originally created by Sigmund Freud; he and his followers made it popular among psychoanalysts in the first half of the 20th century, meanwhile American personality psychologists like GW Allport, HA Murray or Erik H Erikson also contributed to its development. Due to the hegemony of quantitative-positivist research in the 1960s and the 1970s this method was not favored, but-owing to the success of narrative psychology-from the 1990s we can perceive the renaissance of life history approach and psychobiography in personality psychology. In this article I will try to demonstrate that the application of psychobiography in the training of psychologists could have countless beneficial effects. The most important reason for it that using psychobiography in training could alleviate some major intellectual contradictions between university training and clinical practice, and it could also contribute to the development of psychology as a "rigorous science". In order to understand the importance of this question first I have to analyze the scientific differences between clinical practice and academic research on ontological and epistemological levels.

Keywords

Psychobiography, Training of psychology students, Clinical practice, Epistemology

Psychology: Clinical Practice and University Education

After graduation most of the psychologists start working in applied areas, and only a smaller part of them become an academic researcher. According to Hoffer, et al. [1] in the United Stated-among psychologists who recently received their doctorates-the rate of academic researchers during their research period was only 8%, while the rate of clinical and counseling psychologists together was almost 50%. Nonetheless, university education of psychologists is fundamentally based on the standards of academic research. Students hear a lot about for example the neurobiological basis of psychological functions, learn to use scientific models and theories that accommodate to the expectations of "hard" natural sciences, and also study how to conduct experiments and quantitative empirical research. In my opinion this kind of knowledge-although it is very important, and every psychologist has to know it well-is fairly different from the (often implicit) knowledge that we use in everyday clinical or counseling practice. To justify my statement I will compare the scientific approaches related to academic and clinical psychology (I mean clinical psychology in practice, not in textbooks). My comparison will be intentionally overemphasized, because I know that in real life these antagonisms are not that extreme (Table 1).

According to Murray and Kluckhorn [2] every person is like all the other persons, like some other persons and like no other person-at the same time. In order to understand their patients, clinical psychologists most of the time have to focus on the latter-on the individual and on the personal aspects. Apart from using basic knowledge about "human nature" and the specificities of particular groups (e.g. borderline patients), clinicians

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Table 1: The main differences between clinical psychology practice and academic psychology.

Features of clinical psychology (in practice)	Academic psychology that dominate research and training of psychologists at universities
Individual and personal focus (idiographic approach).	Focusing on generalities (nomothetic approach).
Contextual point of view (including intersubjective, interpersonal, life historical, cultural and historical contexts).	Decontextualizing phenomena. Reductionism.
The aim is to unfold the structure and the meaning of the patients' personal experiences and behavior.	Trying to unfold correlations and causal relationships.
Using complex and holistic models.	Based on using scientific models that are similar to natural scientific models (e.g. "Evolutionary Psychology").
Using qualitative and historical-interpretative methods (W M Runyan).	Using experimental and qualitative research methods.
The "first person point of view" is as important as the "third person point of view".	The "first person point of view" is more important, because it is more scientific.
Understanding is the main target.	Scientific explanation is the main target.
Requires personal and epistemological reflexivity (the role of subjectivity).	Striving for objectivity.
Based on narrative form of thought (J Bruner) and contextualist world view (Th Sarbin).	Based on paradigmatic/logical scientific form of thought (J Bruner). Based on mechanistic world view (Th Sarbin).
Meta-theoretical framework should be methodological hermeneutics (D Rennie).	Positivism as meta-theoretical framework.

must develop their own way to get in touch with their client's unique personality in order to understand them. To get hold of that, they have to apply something that is similar to what Robert Stolorow, George Atwood and Donna Orange call "phenomenological contextualism" [3]. It means that we have to deal with personal emotional experiences ("phenomenological") organized in intersubjective, interpersonal, life historical, cultural and historical contexts ("contextualism"). Taking all these aspects into consideration, the psychologist and the patient unfold the structure, the pattern and the meaning of the patient's behavior and experiences *together*. "Together" means that the first person point of view (the patient's perspective) will be taken into consideration as well as the clinician's third person point of view [4]. Their subjective perspectives have their own "horizons" [5], and where the two horizons overlap-owing to the psychologist's empathic skills and the client's introspective capacity-mutual understanding is being constituted as "intersubjectivity".

This process is not based on the application of quantitative empirical research or the models of natural science, because the clinician's work is more similar to the researchers who use qualitative approach and "historical-interpretative methods" [6]. But psychologists are usually not trained in phenomenological-hermeneutical traditions, so they unfortunately have to act "instinctively" without any epistemological reflexivity. The perspective of a clinician is always under the influence of subjective attitudes, beliefs, personal and professional prejudices that are formed by sociological and psychological factors[a]. Subjectivity in clinical work is unavoidable, so instead of forcing objectivity-which leads to the hidden prevailing of subjective factors, from time to time clinical psychologists must apply epistemological and personal reflexivity[b] [7].

Although in the recent decades there have been countless efforts to keep psychoanalysis/psychotherapy/clinical psychology within a positivist framework, fitting to natural sciences and medical discourse [8,9], from ontological and epistemological point of view it is rather problematic. If we don't accept the scientist dogma that there is only *one* way to do science, there are several ways to identify the *real* scientific background of clinical activity. For example Jerome Bruner [10] stated that there are two basic forms of thinking: Paradigmatic/logical scientific and narrative. Clinicians have to deal with different topics (love, grief, identity) that do not fit into the frame of the paradigmatic/logical scientific form of thought; that is why they must apply the narrative form of thought, because the nature of their subject requires this. A second aspect is connected to the ideas of narrative psychologist Theodor Sarbin [11], who adopted the Stephen Pepper's old "world hypotheses" concept. According to this model "mechanism" is a significant, dominant world view in Western cultures that determines scientific activity and research, but practical work of clinical psychologists is based on a different world view: "contextualism", because it's impossible to understand clinical phenomena without the contexts of being [12]. David L Rennie [13,14] argues that qualitative approaches in psychology require a metatheoretical framework that is different from the epistemological basis of radical empiricism and qualitative methods.

[a]See "The Sociology and Psychology of Knowledge" in *Faces in a Cloud* by Robert D Stolorow and George E Atwood pp. 23-26 [57].

[b]This feature is also a part of psychoanalytic therapy's historical development. In the earlier decades, "countertransference" (a special form of subjectivity) was regarded as a harmful aspect, but later, in the second part of the 20th century, analysts began to consider it as a useful clinical tool in the process of diagnosis and in understanding [58].

This proper framework is not positivism, but "methodological hermeneutics" that originates from the works of German philosopher Wilhelm Dilthey. In sum the scientific foundation of clinical work is connected to the traditions of "human science psychology" [15].

If we take a look at the university education of psychologist, although a very large part of them will become clinical and counseling psychologist, we find something radically different. Psychologists are mostly trained to apply scientific models and theories that are about to fit the standards of natural sciences: "Evolutionary Psychology" or "Neurosciences" are like this. These are very important perspectives in academic research, but their relevance in average clinical practice/therapy is almost negligible [16]. For example, if a female patient has serious problems with her intimate partner's fidelity, an a therapist starts talking about the different strategies the two sexes had developed one million years ago to ensure their survival and reproductive success, it will not contribute to the therapeutic process at all. Also, the presumption that mirror neurons are "responsible" for the empathic responses is irrelevant information in clinical practice. In contrast there are ideas that are at the heart of the matter, much more than the methods of quantitative empirical research, but students never hear about them unless somebody personally draws their attention to them. Among several others I found that for example Karl Jaspers' ideas about "boundary situations" or his emphasis on phenomenology and hermeneutics in diagnostic process [17,18] are highly useful concepts in this context, but even so Jaspers will never be the part of a syllabus.

When psychology students learn how to conduct scientific researches or they write theses or papers, their activity is mostly focused on experimental and correlational studies due to Lee Cronbach's classic statement: "there are two disciplines of scientific psychology: correlational and experimental" [19]. The aim of these studies is to generalize, that's why students focus on the specificities of "human nature" or particular groups of people (nomothetic approach) and apply statistical tests. To carry out these kinds of studies or to identify correlations or/and (linear) causal relationships between phenomena, we teach future psychologists to use reductionists approach and encourage them to decontextualize the phenomenon that is about to be investigated. In contrast they will never meet a decontextualized phenomenon during their practical work, or if they tried to apply this approach in a clinical case, that would be ineffective or even confusing. For example if a psychologist finds his/her patient aggressive and starts thinking about the correlating personality traits according to some empirical studies from the past few years, considering the role of amygdale in these aggressive reactions, s/he will fail to manage the clinical process. Instead, s/he will need to understand the role of aggression in the patient's actual and past life.

In academic psychology, the emphasis on "third person point of view" [4] is related to the idea of "scientific objectivity". Objectivity means that-according to this approach-the most important aims of the studies are the scientific-objective explanations of the investigated phenomena. In order to achieve this, the explanations often switch from psychological (the level of experience) to non-psychological ontological levels (e.g. neurobiology), because scientific authority consider it as the level of "real" science. It is related to the "paradigmatic/logical-scientific" form of thought according to the above mentioned Jerome Bruner [10], which is very useful in quantitative empirical research, but a lot of important psychological issues (love, grief, identity, etc.) is inaccessible in this way-especially in psychotherapy. The "root metaphor" that describes this scientific perspective is "mechanism", and we can agree with Sarbin [11] that psychologists who follow this tradition emphasize order, predictability and linear causality. But the phenomena that clinicians experience in their practice are not sometimes neither predictable nor reasonable[c]. The meta-theoretical framework for academic approach is positivism. Because psychology had committed itself to positivistic methodology in order to be accepted as a "real" science, this explicit epistemology led to an implicit ontology: (Cartesian) materialism [20]. Cartesian materialism is a presupposition that "the mind can be identified with the brain, and that the brain is a self-contained organ that can be understood in isolation from the world" [4]. This approach is following the traditions of "natural science psychology" [15]. But, as we will see below, this scientific orientation sometimes seems to be inconsistent with the nature of the subject in clinical psychological practice.

The Epistemological Background of Diagnostic Work

To unfold this inconsistency, let's see that what kinds of phenomena come into view in clinical practice. Our first major task is always to diagnose the problems of the patients by during the clinical interview. The diagnosis about identifying symptoms and syndromes, but in the case of mental disorders-unlike in somatic medicine-symptoms are not visible physiological lesions or objective data produced by instruments or measurement. (It is debatable whether the results of psychological tests can be considered as objective data or not.) On one hand the phenomena regarded as symptoms are: a) Behavioral manifestations or b) Personal experiences and internal psychic contents/structures that can be localized within the patient's mind or personality. a) Behavioral manifestations like "pattern of unstable and intense interpersonal relationships" (in case of borderline personality disorder) sometimes cannot be observed directly in the test situation

[c]We can consider Spanish existentialist Miguel de Unamuno's sentence in here: "everything vital is anti-rational, not merely irrational, and that everything rational is anti-vital" [59].

(except as the signs of "transference" in dynamic psychotherapy), because they are very complex and they manifest themselves longitudinally and in interpersonal context. Clinicians mostly learn about these behavioral manifestations according Aside from the "scenic information" [21] of the situation we are working with texts that are constructed by the patient about his/her current and past life, attitudes, plans, fears, etc. It means that if we want to approach these reports scientifically, we have to be ready to interpret linguistic products according to hermeneutic tradition, and we are not relying on medical knowledge. Ricoeur [22] argued that for example a psychoanalyst never analyzes a "dream" directly, because the only thing that can be shared is a verbal report about the dream. According to Freud's discoveries, says Ricoeur, symptoms, dreams and parapraxes (like slips of the tongue) have similar structure: They have a latent content that transformed into manifest forms by primary process thinking. So the psychological phenomena of psychoanalytic investigations are "language-like", but even so clinicians never have a course about semantics or semiotics.

The other kinds of phenomena that are regarded as "symptoms" are b) Personal experiences and internal psychic contents/structures that can be localized within the patient's mind or personality. Clinicians usually learn about them by talking with the patients, so the client's "first person point of view" is the only authentic source of our knowledge from this realm[d]. If we take for example "chronic feelings of emptiness" in borderline personality disorder, we will find that this phenomenon cannot be in the scope of any kind of natural scientific investigation[e]. More than a hundred years ago Karl Jaspers [17,18] argued that psychological experiences and conditions, the subject of psychopathological investigations are always comprehended *phenomenologically*. This is a huge contradiction, because for example psychiatrists, the medical experts of mental disorders in the 21st century are mostly trained to be natural scientists. They know a lot about the supposed neurobiological background of the symptoms and disorders, but the diagnostic process in their everyday practice is not based on medical tests or fMRI examination, but on human communication and phenomenological methods.

After the clinician successfully identified the significant psychological phenomena regarded as symptoms, s/he has found their meaning by interpretation, which means that s/he has to link them to: 1) Actual life conditions, and 2) To life historical events and motifs. According to Jaspers [17] understanding (*Verstehen*) in this field is based on "descriptive psychology". He borrowed it from Wilhelm Dilthey, who declared that "descriptive psychology" is the methodological basis of "Human Sciences" in order to understand the meaning (*Verstehen*) of cultural and historical phenomena-from the products of poetic creativity to historical architecture [23]. "Analytic" psychology is related to natural sciences, and its aim is scientific explanation[f]. From the last years of the 19th century Dilthey switched to "hermeneutics", because he realized that human mind can be investigated only indirectly, via its creative products [24] but the idea behind is similar. As I referred to it formerly, recently David Rennie [13] emphasized that *methodological hermeneutics* founded by Dilthey is the proper meta-theoretical framework for qualitative psychology. The fact that (clinical) psychology and psychoanalysis cannot do without hermeneutics is generally known for decades [25,26].

If we intend to unfold the entire epistemological background of psychological diagnostics, besides *phenomenology* and *hermeneutics* we also have to consider *structuralism*. Structuralism is about analyzing the relations between specific phenomena to identify meaningful patterns. A psychological-psychopathological phenomenon is always connected to actual life conditions (synchronic approach) and to life historical events and motifs (diachronic approach). "The adequacy of a structural explanation-write Stolorow and Atwood is measured not by its predictive power, but rather by the degree to which it brings together in one unitary interpretation domains that, at first sight, seem disconnected by the observer. A key concept in this integrating function is that of invariance. Invariance refers here to a structural configuration that remains constant over some set of transformations" [27]. So when a clinician is trying to identify the above mentioned "pattern of unstable and intense interpersonal relationships" in borderline con-

[d]Of course there have been great scientific and laic expectations ever since the "decade of the brain" (the 1990's) that sometimes in the near future brain research and neurosciences will find neurobiological solution to every problem concerning "thoughts", "feelings" or "behavior". Being aware of this false reductionist orientation no wonder, that-despite of its 1 Billion € budget-Human Brain Project is facing a scientific failure [60].

[e]One could argue that this is not true as-like in "neurophenomenological" researches-we are able to study the neurobiological activity during the patient's verbal report using brain mapping techniques to find the neuroanatomical basis of these "chronic feelings". I would like to add three points to this presumption.

1. A brain structure doesn't have a special "meaning" like "feeling of emptiness", it is constructed by the subject using a metaphor ("emptiness").
2. "According to the dynamical systems approach of neuroscience, the neural activation that underlies our experience is not localized in a specific brain area, but involves the rapid and transient integration of functionally distinct and widely distributed brain areas" [4], so it would be rather pointless to search for specific "brain areas" that are "responsible" for these experiences.
3. If somehow this research successfully ended up in finding specific brain areas behind this experience, it is hard to imagine that this would essentially influence diagnostic work in everyday practice.

[f]It's not hard to identify Dilthey's "descriptive" and "analytic" psychologies with "human science psychology" and "natural science psychology" that I have already mentioned above according to Walsh, Teo and Baydala [15].

ditions, s/he has to unfold the structural configuration of actual relationships (synchronic view), and also has to study invariance of significant interpersonal experiences in life history (diachronic view). "Unstable but intense interpersonal relationship" is going to be an invariant, meaningful pattern, or, in other words, a structure.

What does that mean? Clinicians (clinical psychologist, psychiatrist) are mostly trained according to the traditions of academic researches according to the medical discourse. They are educated to use models and methods that are mostly based on paradigmatic form of thought (Bruner), mechanistic world view (Sarbin), positivism and Cartesian materialism. But when they meet clinical cases in practice, they use phenomenology, structuralism and hermeneutics, because the nature of their subject is forcing them to do so. It is not likely that there is a simple university program that lays any stress on phenomenology, structuralism and hermeneutics, so clinicians have to apply these perspectives implicitly, in a naïve and unreflected way. One can argue that-thanks to their post gradual clinical training and professional experiences-most of the clinicians learn to diagnose successfully. But wouldn't it be more comforting, if theoretical-methodological knowledge and clinical practice were more integrated, and even students would posses relevant, explicit scientific knowledge about the activity that they have to carry out?

Someone could argue that these contradictions are exaggerated, and according to the "scientist-practitioner model" in clinical psychology [28], students get to know significant theories of different subfields in the classroom, where they also learn how to carry out empirical researches, and when they perform their clinical practical courses at different psychiatric departments, they will develop their clinical knowledge and skills. That would be true, if practice take place at institutes with a psychotherapeutic orientation. But most of the time these practice locations (at least in my home country, Hungary) are mental health institutions that are parts of large hospital complexes where everything is dominated by (bio)medical approach and practice as psychiatry in the 21st century generally identifies itself as "biological" [29]. But as students have to take their practice time in there, if we want them to experience a useful period that helps them in their professional socialization, there are some important aspects that we have to clarify and discuss with them.

As diagnostics is a major task for them, we have to clarify, that psychiatric and psychological/psychotherapeutic diagnoses are not the same. Psychiatric diagnosis is about finding a proper medical category using official nosological systems that would fit to the symptoms manifested by the patient. But for example "depression" as a "simple" diagnosis is not giving enough information about prognosis and indications. It can be a reactive depression connected to an actual emotional loss, it can be a personality problem (depressive personality disorder or dysthymia), a "character depression" of a borderline personality after a breakdown, or an introductory phase of Parkinson's disease [30]. So the psychological/psychotherapeutic diagnosis has to go beyond psychiatric diagnosis in order to learn something about the patient's personality structure, psychodynamics, contact skills, etc. Without these accurate prognostics and indication cannot be made. If these differences are not clarified, students will be forced to accommodate themselves to biological psychiatry[g].

The second problem is connected to the latter. In health care systems-for example in psychiatry departments-a (clinical) psychologist's work and his/her knowledge is most of the time presented as something subordinated to the competence of a psychiatrist. (It also happens in forensics where the psychologist's work only supports the psychiatrist's expertise). The most common argument in this context is that diagnostics in this field requires "medical competence". From epistemological point of view this seems to be based on a historical presupposition. But, as I analyzed it above, the process of diagnostics in this field is not based on biological but on psychological knowledge. When a clinician is identifying significant psychological conditions, s/he is using phenomenological approach (there is no other way to comprehend psychological phenomena like "chronic feeling of emptiness"), when s/he is drawing up context by using synchronic and diachronic points of views, it is based on structuralism. And when s/he is trying to find the personal meaning of behavioral manifestations or personal experiences, interpretations are based on elements described by hermeneutic traditions. As most of the information come from verbal reports of the patient, its interpretation is scientifically seems to be closer to the analysis of text documents than to medical observation. In the strict sense of the word, medical knowledge-concerning the neurobiological background of mental disorders-plays no role in the diagnostic process, because it is related to a different ontological level.

At this point, we come to a paradox. Aside from pharmacotherapy and the management of related medical conditions (e.g. intoxication), psychiatry is borrowing its practical knowledge (diagnostics, psychotherapy) from (clinical) psychology. Nonetheless clinical psychology is often presented as a subordinated knowledge and practice, because the diagnosed conditions are "medical", so their diagnosis and treatment both require medical competence. Of course these disturbances do have iden-

[g]I remember when I was a psychology student and I started to work as an assistant in a huge psychiatry department in Hungary. It was at the end of the 1990s, the heydays of psychopharmacology industry. Everything was about the neurophysiological and biochemical models of different mental disorders and new drugs like SSRIs. Holding on to psychologist identity in this context was not an easy job.

tifiable neurobiological aspects (every mental process has), but presenting this aspect as the "essence" or the most important parts of the pathologies seem to be a part of "medicalization", the questionable extension of medical discourse [31]. Medicalization and psychiatrization of human complex conditions is only partially successful; the regular qualitative and quantitative changes of the DSM-systems throughout the years show that even the identification of the disorders is highly problematic, and a significant part of these categories are mere constructions [32]. As Foucault pointed out decades ago: "One might ask oneself whether our distaste does not spring from the fact that we give the same meaning to the notion of illness, symptoms, and etiology in mental pathology and in organic pathology. If it seems so difficult to define psychological illness and health, is this not because one is trying in vain to apply to them, en masse, concepts that are also intended for somatic medicine?" [33].

Returning to Idiographic Methods

Medicalization and psychiatrization are the special forms of a more global trend called scientism. According to this, the ideas and methods of natural sciences are regarded as the only acceptable way in search for the "truth" about mankind. Scientism therefore is called "the new orthodoxy" by some contemporary authors [34]. This phenomenon is not brand new in Western intellectual history. It seems to be a new edition of a trend identified by Edmund Husserl a hundred years ago called "naturalism". Husserl argued that the approach of natural sciences is not suitable to be a starting point for psychology and philosophy. "To follow the model of natural sciences-he wrote-almost inevitably means to reify consciousness-something that from the very beginning leads into absurdity, whence stems the constantly renewed toward the absurd problematizing and the false orientations of the investigation". In order to avoid these false orientations, says Husserl, we have to develop methods that fit the investigated subject. "The true method follows the nature of things to be investigated and not our prejudices and preconceptions [35]".

I think that Husserl's propositions are now more topical than ever. The spreading of scientism according to the development of research technology in the 21st century (brain imaging, etc.) often leads to Husserl's "absurd problematizing" and "false orientations" in psychology. We can experience the spread of "neuromania" (Tallis, 2011) [36] or the emergence of concepts and trends like "neuropsychoanalysis", which is "in fact an oxymoron, glossing over important conceptual distinctions and fusing separate universes of discourse" [37]. Scientism also appears in psychotherapy, when the efficiency of a method is often related to detectable structural changes in the given regions of a patient's brain [38]. If you type for example "mindfulness" or "meditation" and "brain changes" in Google search, you will find dozens of articles that deal with this topic; you can even find studies like "The Neuroscience of Good coaching". This trend fits "traditional psychotherapy research" which "tends to reduce human beings and human relationships to 'variables' that can be measured, calculated, and correlated" [39]. Robert D Stolorow suggests that instead of this approach, which belongs to "technological way of being" (Heidegger), it was time "to return to idiographic methods in studies of the psychotherapeutic relationship". In my opinion this return to the idiographic methods is also topical in the training of (clinical) psychologists, because-according to my analysis above or Allport's [40] standpoint-a clinical psychologist most of the time focuses not on correlation of traits or brain structures, but on the uniqueness of an individual existence.

The idea that it is necessary to concentrate on the idiographic dimension in the training of psychologist is not new. Henry A Murray founded the tradition of personology at Harvard University Clinic in the 1930's, and in the second half of the 20th century this tradition-which emphasizes the importance of in-depths, systematic study of individuals-influenced a clinical psychology doctoral program at Harvard [41]. Robert D Stolorow was trained in this program, and when I asked him about it, he told me the following: "When I was a grad student in the clinical psych program at Harvard in the late 1960s, the assessment course that I took consisted in the whole class studying one person for the entire semester-using biographical material, clinical interviews, and psychological tests. The whole class then wrote up a collaborative case report. It was a great way to learn!" (personal communication).

How can we validate these principles in education? I would suggest four points in this context. *First*: Before starting their institutional practice, students should be prepared that instead of seeing patients as typical representatives of disorders, they have to focus on the individual's unique personality and life history. That would help them to understand the organization and meaning of a patient's behavior and subjective experiences, which always presupposes intersubjective, interpersonal, cultural, historical contexts. I believe that without using complex theories about personality (psychoanalysis, personology, existential psychology, narrative psychology) it is not possible. That is why it is not acceptable that we inspire students to use as few of theory as possible for example in their papers or theses, and to focus on the empirical part and data process. Statistics will never make anyone a good clinician. In our practice we encounter phenomena which are hard to understand if keep them in the narrow framework of health sciences. It is not accidental that in 1926 Freud wrote the following about the training of analysts: "Analytic instruction would include branches of knowledge which are remote from medicine and which the doctor does not come across in his practice: The history of civ-

ilization, mythology, the psychology of religion and the science of literature. Unless he is well at home in these subjects, an analyst can make nothing of a large amount of his material" [42]. Jaspers [17] also pointed out that without education in human sciences, psychiatry (and clinical psychology) is not relevant. When students get prepared for clinical practice, we also have to emphasize that in they are going to use "historical-interpretative" methods [6], and because their subjectivity always matters, they have to apply self-reflections from time to time [7]. They have to be there as an authentic person, they can't hide behind the mask of an expert or an objective scientist.

Second: During their preparation, we have to emphasize the differences between psychiatric and psychotherapeutic diagnostics; I unfolded the reasons of it above. *Third*: Students have to develop special, professional self-awareness that exceeds the everyday level. The understanding of others does not exist without understanding ourselves, because-according to Dilthey-understanding is the rediscovery of the I in the Thou [43]. In this field "the investigator can, indeed must draw upon his own experience and self-knowledge to guide his interpretations of the lives of those he studies" [27]. Somehow we have to support this process at universities, because a psychologist's personality is a "working tool". But this cannot be related entirely to the training institute. Teachers can be role models and supervisors but cannot serve as "training analysts" because there is a risk of confusing the roles or develop transference and countertransference between students and professors [44]. *Fourth*: The conditions of theses-writing have to be changed in clinical programs. Besides the empirical part, the student should present something practical, a case study or a life history analysis (psychobiography)[h]. I would like to argue in last part of m article that on this level of education psychobiography is a proper choice for that. Besides that it is integrating idiographic approach with contextual perspective and illuminating the process and the nature of interpretation, it has got several other benefits as well.

Psychobiography: Its Utility in the Training of Psychologists

Psychobiography is an idiographic, qualitative, "historical-interpretative" research method [45]. It is "the systematic use of psychological (especially personality) theory to transform a life into coherent and illuminating story" [46]. This method was created by Sigmund Freud in 1910 with writing *Leonardo da Vinci and a Memory of His Childhood* [47] although of course has it has its historical roots in pathography, philosophy and biography writing. Following Freud's initiation, until the 1950s psychoanalysts had written hundreds of psychobiographies and pathographies. From the 1930s, life historical approach also influenced American personality psychologists like GW Allport, HA Murray and RW White, but due to changes of the trends in psychology, psychobiography went out of fashion after World War II. During the following decades, Erik H Erikson made some important contributions to this genre, but psychobiography began to rise again only from the 1980s and 1990s owing to the success of narrative psychology [45]. Contemporary psychobiography [48,49] is a bit different from its historical forerunner. Although psychoanalytic concepts still play important roles in interpretations, contemporary version is more eclectic theoretically, more accurate methodologically, and it has started to widen its focus. Besides investigating eminent artistic creativity, psychobiography writers began to pay attention to scientific creativity and other historically significant figures like politicians as well. The authors are trying to avoid psychopathological arguments, theoretical one-sidedness, reductionism, speculations and the over-psychologization of artistic problems.

Elms [50] argued that psychobiography could do a lot for psychology. It "could substantially remedy some of the problems faced by psychology" by helping our science to study the personally significant instead of the statistically significant, and by understanding important single cases, it could provide ideas for new theories. I believe that these beneficial influences for psychology could start in education, according to the ideas originally raised by HA Murray in the 20th century. Writing a psychobiography is a thorough and in-depth work, which requires the integration of psychological knowledge coming from different subfields in an original and creative way. This occupation also deepens one's knowledge about human nature and conduct in real life context, much more than quantitative empirical researches do. It also deepens self awareness, as understanding of the other and the self is going hand in hand [43] as we can see it in psychotherapy either. That is why I believe that writing psychobiography is a fine preparation for clinical and therapeutic activity, blazing a trail for the development of *phronesis* aka practical wisdom [39].

Although psychobiographical analysis is an intellectual work, one cannot avoid getting emotionally involved during the investigation[i]. This is a very important motivational factor, and psychologists have to learn how to handle these situations. Even Erik H Erikson [51] argued that when a psychologist is doing an interpreta-

[h]At Eötvös Loránd University, Institute of Psychology, Department of Clinical Psychology and Addiction, (Hungary, EU) this change is actually going on.

[i]"The will and the intelligence have need of one another, and the reverse of that old aphorism, 'nihil volitum quin præcognitum', nothing is willed but what is previously known, is not so paradoxical as at first sight it may appear 'nihil cognitum quin prævolitum', nothing is known but what is previously willed. Vinet, in his study of Cousin's book on the *Pensées of Pascal*, says: The very knowledge of the mind as such has need of the heart. Without the desire to see there is no seeing; in a great materialization of life and of thought there is no believing in the things of the spirit" [59].

tion of a record or document, s/he has to clarify what are the personal functions of writing the review writing synchronically and diachronically. It contains a lot of personal and psychological aspects-for example ithe choice of subject-which are very important [52]. If a psychologist is getting aware of his/her own psychological motifs by self-reflection, it can contribute his/her personal and professional development-without any kind of risk because of the "optimal/aesthetic distance" [53].

Writing psychobiographies has several methodological advantages as well. Beside personal reflections, qualitative researchers always have to reflect on epistemological issues [7]. Epistemological reflexivity would enhance the students' awareness in this field, helping them to avoid "absurd problematizing" and "false orientations of the investigation" [35]. Just because they have to use public data, they can get important first person and third person documents from different sources. In a clinical case study this is more limited, because we cannot start investigations about our patients outside the clinical situation. The more data we have, the more interrelations we can unfold, and-as the subject of the psychobiography is usually passed [54], there would be no ethical problems in uncovering any kinds of connections or interrelations. As the subject is a well known, significant person, conclusions can be evaluated by others easier according to public data; in clinical case presentations we only get to know the subject through the lenses of the reporter. And finally, because in psychobiography we usually don't rely on diagnoses, students can be stimulated to go beyond psychopathology, and focus on deeper existential questions. That can shed light on the differences between psychiatric and psychological diagnoses too.

Ponterotto, et al. [55] published a study about psychobiographical courses in the United States. They found few psychology courses specifically in psychobiography, but they identified a larger number of those that incorporate psychobiographical and/or narrative elements. I am convinced that if psychobiography was a more common subject of methodological courses in the training of psychologists, the beneficial effects mentioned above would contribute the dissolution of the inconsistencies between education and clinical practice. In the spring semesters of 2016 and 2017 I had a chance at Eötvös Loránd University, Budapest, Hungary to have a psychobiography course at the Department of Clinical Psychology and Addictology. In the curriculum I divided the material into six parts (one occasion was 2 × 90 minutes). All of them were divided into two subparts. The structure of the curriculum was the following:

Introduction and history of psychobiography

- The place of psychobiography in the system of psychology.
- International a and national history of psychobiography.

The scientific foundations of psychobiography

- Ontology I: What is man? (Existential philosophy), Ontology II: What is the ontological status of a phenomenon studied by psychobiography?
- Epistemology: Phenomenology, Structuralism, Hermeneutics.

Starting a psychobiographical analysis and theoretical background

- Choosing a subject and research questions. Collecting data: First and third person documents, source criticism.
- Theoretical background: Psychoanalysis, personology, existential psychology, narrative psychology.

Handling data

- Indicators of psychological saliency by I. Alexander, prototypical scenes by W. T. Schultz.
- Narrative identity and life story model by D. P. McAdams, S. Tomkins' script theory, etc.

Interpretation and evaluation

- The process of interpretation.
- Evaluation, limitations, the questions of education (Who is able to write a psychobiography?).

Application of psychobiography

- Eminent artistic creativity.
- Eminent scientific creativity.

At the end of the semesters students had to write a psychobiographical analysis about a person that they chose by themselves. I also asked them to give me a written feedback about the course anonymously. According to these feedbacks, students liked the integrative-holistic perspective, and they really enjoyed talking about exciting subjects (like creativity, that they never learned about in details before). They also found this course pretty practical, which could influence their work later. What they didn't really like was the too much philosophy, and they were also unsatisfied because the practical examples came only at the end of the course. I think that if these kinds of courses (not necessarily with the same curriculum structure) would be more regular in the education of psychologists, we would be able to identify and evaluate the beneficial effects of life history approach.

Conclusion

In this paper I have tried to argue that from an epistemological point of view there is a huge contradiction between the training of psychologists at the university and (clinical) practice. The former is mostly based on positivism and on the models of "hard sciences", while the latter is based on phenomenology, structuralism

and methodological hermeneutics. The foundations of the latter are not parts of the courses at universities, although later every clinician has to use it while exploring the patient and trying to understand the interrelations between behavior, personal emotional experiences and life history, but most of the time it happens implicitly. My proposal is that psychobiographical courses at universities would bridge the gap between training and practice, and it would enhance the methodological (and ontological) consciousness of psychology students.

Psychobiography (or, by extension, life history approach) can also contribute to the solving of psychology's (ontological) problems that Yanchar & Hill [20] analyzed in their article entitled *What is Psychology About?* Psychology as we use it in clinical practice and counselling is not neurology, psychiatry, sociology or zoology. It is dealing with personal experiences and their meanings that are related to historical and cultural contexts. Of course this complexity is very hard to conceptualize, but to narrow our focus according to Cartesian materialism-in order to fit the criteria of "science" dominated by the powers of hard sciences-will lead to the spectacular impoverishment of psychology.

If we take a look at the current psychological literature, we see that almost everything is about happiness and brain research or the effectiveness of techniques like mindfulness or meditation. We might get a feeling that is similar to Husserl's, who wrote the following about the philosophical (and psychological) products of his time: "In fact, faced with this literature, once can only be amazed, at the decline of the sense for the extremely profound problems and difficulties to which greatest spirits of humanity have devoted their lives", [35]. Husserl argued that in order to become a "rigorous" science, philosophy has to find its *own* foundations, *own* subject and *own* methods. I think that psychology is facing similar problems in the beginning of the 21st century. On one hand, psychology might dissolve in the naturalism of neurosciences and brain research, and on the other, it could end up in the shallowness of everyday psychology by focusing on "happiness" and the evident techniques that lead us to be "happy". I am convinced that no brain research or happiness technique will ever save us from the existential dramas that we all have to face in our life courses several times, and those dealing with these things what make us human. If we are able to acquire our boundary situations it will lead us to personal freedom and authentic existence [56].

I really hope that psychobiography and life history approach can contribute to establishing psychology as a "rigorous science" by identifying its own ontological and epistemological basis and accurate methods. It does not mean that I am trying to devalue the importance of natural sciences in human research, or I am saying that psychology cannot learn anything from them. But I agree with Wilhelm Dilthey, the father of modern hermeneutics and the philosophical forerunner of psychobiography [45], who wrote the following about psychology more than 120 years ago: "It is not by transporting into our domain the methods found by the great scientists which we display their true disciples, but by adapting our inquiry to the nature of our objects and thus conducting ourselves toward our knowledge as they toward theirs [23]".

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