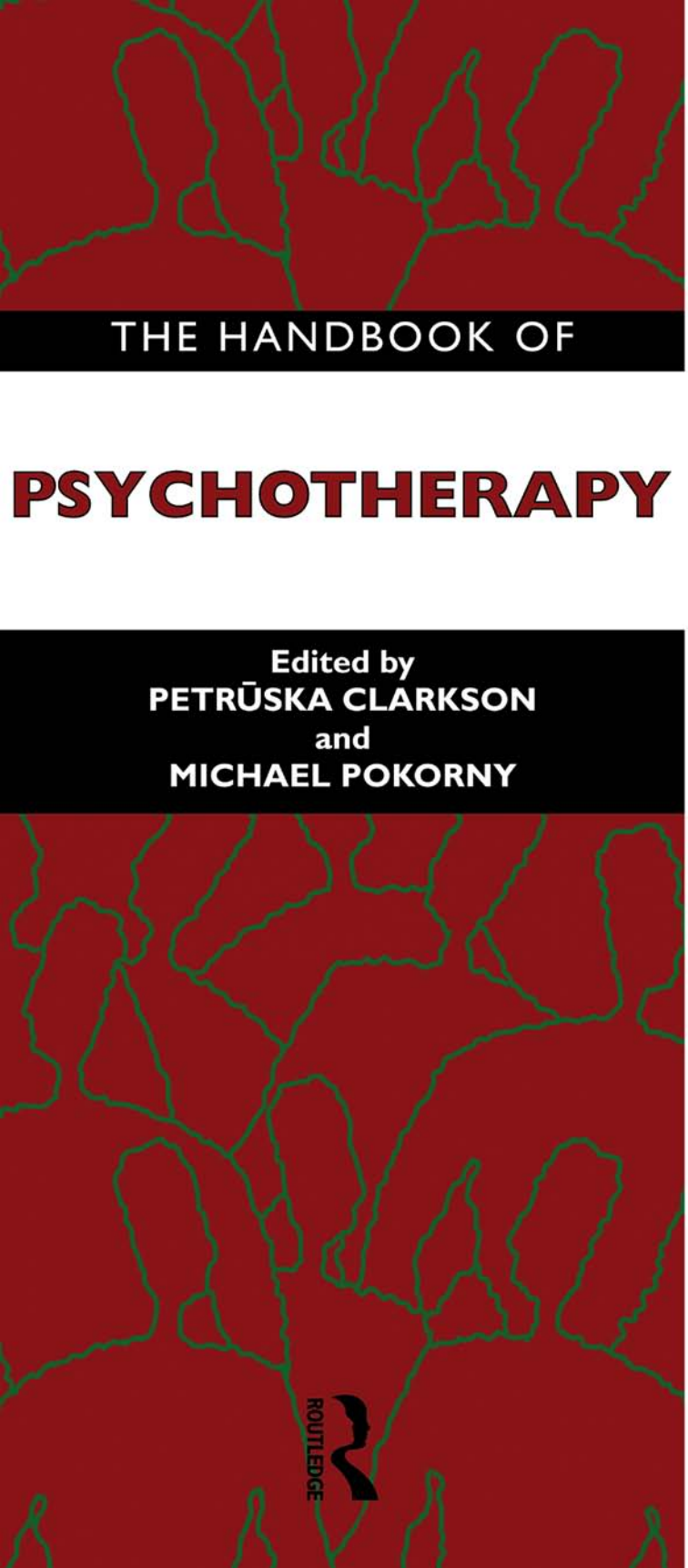
THE HANDBOOK OF
PSYCHOTHERAPY
Edited by
PETRŪSKA CLARKSON
and
MICHAEL POKORNY
ROUTLEDGE

HANDBOOK

The handbook of psychotherapy

Psychotherapy is a fast-growing profession, and *The Handbook of Psychotherapy* offers a unique and comprehensive overview of its many aspects. The editors and contributors are all highly experienced practitioners who articulate, singly or jointly, a particular viewpoint, approach or opinion to produce an overall perspective on psychotherapy today. Each brings a different emphasis to the relevant issues, and the creative tension of the dialogue between them contributes to a lively and well-informed picture of theory and practice.

Presented under five main headings – the nature of psychotherapy and its research, its culture, modalities, settings and issues – the book offers a rich source of information and reference.

The *Handbook* has been written for all health professionals, including nurses and general practitioners; for social workers; for psychotherapists in training; for anyone considering psychotherapy as a career or seeking psychotherapy; for voluntary organizations; in short, for all those who need or wish to know more about psychotherapy.

Petrūska Clarkson, MA, PhD, AFBPsS (BPS), is a chartered clinical and counselling psychologist, lecturer and supervisor, consultant integrative psychotherapist, founder director of **metanoia** Psychotherapy Training Institute and founder of the British Institute for Integrative Psychotherapy. She is the author of numerous papers and books in the field of psychotherapy, supervision, organisations and consultancy. She is past Chair of the British organisation of the Society for the Exploration of Psychotherapy Integration, and is also on the British Psychological Society Board of Examiners for the Diploma in Counselling Psychology.

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Edited by
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and
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The publisher has gone to great lengths to ensure the quality of this reprint but points out that some imperfections in the original may be apparent.

Contents

Illustrations

FIGURES

TABLES

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Gillian Butler, PhD, CPsychol., after qualifying as a clinical psychologist, worked as a therapist in the NHS offering short-term psychological treatment to patients referred to a busy out-patient department. She then held a research post in Oxford University Department of Psychiatry for nine years, and specialised in the development and evaluation of treatments for the more complex and long-standing anxiety disorders. In addition, she has trained as a cognitive therapist and has always been interested in developing a wide range of clinical skills. She now works for the NHS again, and divides her time between therapy, supervision, training, teaching and writing.

Petrūska Clarkson, MA, PhD, is a Chartered Clinical Psychologist and practising psychotherapist, supervisor and organisational consultant. She is Principal Clinical Psychologist of the **metanoia** Psychotherapy Training Institute in London. She was Chair for the British Institute of Integrative Psychotherapy (BIIP), which is affiliated with the Society for Exploration of Psychotherapy Integration (SEPI International). She has written numerous papers in the field of psychotherapy, supervision, counselling and organisations, and several books, amongst which are *Transactional Analysis Psychotherapy: An Integrated Approach* (Routledge, 1992), *Gestalt Counselling in Action* (Sage, 1989), *On Psychotherapy* (Whurr, 1993) and *The Therapeutic Relationship* (Wiley, in press).

Alan Cooklin, MB, ChB, FRCPsych., DPM, is Consultant in Family Psychiatry at the Marlborough Family Service and University College and the Middlesex Hospitals, and Honorary Senior Lecturer at University College London, and Birkbeck College, London. He was Chairman of the MSc degree course in Family Therapy between the Institute of Family Therapy and Birkbeck College. He is currently Chair of the Institute of Family Therapy and Clinical Director in the North-west London Mental Health NHS Trust.

Louise Embleton Tudor, Adv. Cert. Biodynamic Massage, Dip. Dram. Art, Dip. Ed., Dip. Psychotherapy, ITHP, is an Integrative Psychotherapist. She worked in further education and in the mental health field before training at the Minster Centre for Analytic and Humanistic Psychotherapy, and is a member of the Institute for Traditional and Humanistic Psychotherapy.

She has undertaken further training in Biodynamic Massage at the Chiron Centre for Holistic Psychotherapy and in the Supervision of Counsellors and Psychotherapists at **metanoia** Psychotherapy Training Institute, and has recently established herself in Sheffield as a freelance psychotherapist, supervisor, trainer and consultant.

Sheila Ernst, BA, CertEd, Member Inst. Group Analysis, has worked at the Women's Therapy Centre in London for many years. She is in private practice as a member of the Group Analytic Network and trains counsellors and psychotherapists. She is co-author (with Lucy Goodison) of *In Our Own Hands* (Women's Press, 1981) and co-editor (with Marie Maguire) of *Living with the Sphinx: Papers from the Women's Therapy Centre* (Women's Press, 1987).

Alexandra Fanning trained as a psychoanalytic psychotherapist with the Arbours Association and has held a number of posts within it. She founded and was first Chair of the Arbours Association of Psychotherapists. Having been for many years on the Arbours Training Committee, she is currently the Director of Training. She is also a delegate to the UKCP, having been delegate to the prior organisations, the UKSCP and the original Rugby Psychotherapy Conference, where she was a member of the Working Party and the first treasurer in the period leading up to the inauguration of the UK Standing Conference for Psychotherapy. She is in full-time private practice as a psychoanalytic psychotherapist with a special interest in conjoint marital psychotherapy.

Tanya Garrett, BA, MSc, CPsychol., AFBPsS, is a Chartered Clinical Psychologist and Associate Fellow of the British Psychological Society. She works as a Clinical Psychologist with Walsall Community Health Trust where she manages the Clinical Psychology Service to children, young people and families and provides a psychotherapy resource for the Clinical Psychology Department. She is currently undertaking PhD research at the University of Warwick in the field of sexual contact between psychotherapists and their patients.

Gill Gorell Barnes, MA, MSc, is Senior Clinical Lecturer in the Child and Family Department of the Tavistock Clinic, Consultant to the Training Department at the Institute of Family Therapy, and was previously Director of Training at the Institute for many years.

David Gowling, Dip. Soc. Stud. (Oxford), CQSW, initially worked in industry for twelve years. After qualifying as a social worker, he specialised in work with adolescents, with child abuse and in mental health. During this period he trained and qualified as a psychotherapist. Currently he has a private psychotherapy practice and is involved in both the training and supervision of counsellors and psychotherapists. He is a qualified

Transactional Analysis Clinician and a Provisional Teaching and Supervising Transactional Analyst (with Clinical Speciality).

Pat Grant, MSc (Counselling Psychology), BEd (Hons), RNT, DN, RMN, SCM, RGN, is a Senior Lecturer at the University of Greenwich, London, where she lectures in education and counselling psychology. She is a Counselling Psychologist involved in counselling and supervision. She is a black woman who has done a lot of work with black clients and black supervisees in England. One of her many interests in the field of counselling is working with bereaved clients.

Helena Hargaden, BA (Hons), PGCE, CTA, CIP, BAC Accredited Counsellor, has a psychotherapy and supervision practice in South-east London and is a Primary Tutor on the Diploma in Counselling course at **metanoia** Psychotherapy Training Institute. Previously she was a lecturer in communication studies.

Peter Harper, BSocSc, BA (Hons), MSc (Clinical Psychology), AFBPsS, is a Consultant Clinical Psychologist working in the Child Health Directorate, Northampton. He has a wide range of experience as a clinician, psychotherapist, trainer and supervisor, both in the United Kingdom and abroad. He is a member of several professional organisations and is on the Editorial Board of *The Child Care Worker*, a journal to which he has made a number of contributions on working therapeutically with children.

Judith Hassan, BSc (Hons), CQSW, Dip. App. Soc. Stud., began work at the Jewish Welfare Board in 1969. Since 1977 she has specialised in working with survivors of the Nazi Holocaust, and has chaired the Survivor Centre Steering Group. In 1990 she became Director of Shalvata (Jewish Care), a therapy centre for adults with emotional difficulties, and in 1992 Chair of the Management Committee of the new Centre for Holocaust Survivors in Hendon, and she maintains management responsibility for both centres. In 1992 she organised the European Conference for Professionals Working with Survivors. She has published numerous papers on survivors, presented work on radio and television, and teaches rabbis, hospital staff, social services and Jewish organisations.

Peter Hawkins, BA(Hons), MAHPP, PhD, is Organisational Consultant and founding Partner of Bath Consultancy Group, through whom he works with a wide variety of organisations. He is also a psychotherapist and founder of the Bath Centre for Psychotherapy and Counselling. He is co-author with Robin Shohet of *Supervision in the Helping Professions* (Open University Press, 1989).

Paul Hitchings, MSc, BSc, PGCE, Chartered Psychologist, Accredited Counsellor (BAC), is a practising counselling psychologist with over ten years' experience of working with clients individually, in couples and in

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Robert Jezzard, MA, MRCP, FRCPsych., is a Consultant Child and Adolescent Psychiatrist based at the Bloomfield Clinic, Guy's Hospital. He works in the context of a multidisciplinary team of mental health professionals, primarily with young people and their families from South-east London. Although he is based in a hospital, he sees many of the young people in community settings in addition to the clinic.

Adele Kosviner, MSc, AFBPsS, CPsychol., is a Consultant Clinical Psychologist working within the National Health Service in Riverside Mental Health Trust, London. She is at present Chair of the British Psychological Society's Psychotherapy Section and representative of the Society to its Joint Standing Committee with the Royal College of Psychiatrists and to the United Kingdom Council for Psychotherapy.

Tom Leary is a priest in the Church of England. He trained in couples work with the National Marriage Guidance Council, St George's Hospital, and at the Tavistock Institute of Marital Studies. At present he is co-ordinator of family and marital work at Westminster Pastoral Foundation, and also works in private practice.

Christine Lister-Ford, BEd, Dip. Hum. Psych., Training and Supervising Transactional Analyst (ITAA), Recognised Supervisor (BAC), is a director of Stockton Psychotherapy Training Institute where she co-ordinates the four-year psychotherapy training in Transactional Analysis. She is Chairperson of the Training Standards Committee of the Institute of Transactional Analysis. She has maintained a private practice for thirteen years.

Sara Llewellin, BA (Hons), PGCE, is currently the Director of St Giles Trust – a voluntary sector agency providing services for homeless people in South London. She has been active in women's, lesbian and anti-racist politics. She is studying TA at **metanoia** Psychotherapy Training Institute.

James Low, PhD, works as a psychotherapist, supervisor and trainer at the Monroe Clinic, Guy's Hospital and in private practice.

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Oded Manor, BA, PhD, PGDip. App. Soc. Studies and CQSW Dip. Counselling Skills, is Principal Lecturer in Social Work at Middlesex University, London. Previously a Senior Practitioner for group and family work, he continues to supervise group workers and has published numerous papers on the subject. For over twenty years he has been engaged in lecturing and consultancy in various other countries as well.

David Millard, MA, MB, ChB, FRCPsych., is honorary Consultant Psychiatrist to Oxfordshire Health Authority and Emeritus Fellow of Green College, Oxford. He recently retired after twenty years as Lecturer in Applied Social Studies, University of Oxford and consultant at Warneford Hospital. He was previously editor of the *International Journal of Therapeutic Communities*.

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Colin Murray Parkes, MD, FRCPsych., is Honorary Consultant Psychiatrist to the Royal London Hospital and to St Christopher's Hospice, Sydenham. He is author of *Bereavement: Studies of Grief in Adult Life* (Pelican/IUP, 1986), and of numerous papers on the psychological aspects of bereavement, crisis, amputation of a limb and terminal cancer care. He is President of Cruse (Bereavement Care), Scientific Editor of *Bereavement Care* and editorial advisor on numerous journals concerned with hospices and bereavement.

Haya Oakley, BA, PSW, UKCP Reg. Psy. Psychotherapist, was born and educated in Israel, where she graduated as a psychiatric social worker from the Hebrew University of Jerusalem. She is a training committee member of the Philadelphia Association and Chair of the Guild of Psychotherapists. She works as a Psychoanalytic Psychotherapist in private practice and has worked as a community therapist in PA Houses. She appeared on the Channel 4 series *A Change of Mind*, and BBC Radio 4's 'Room to Listen, Room to Talk', and has contributed to 'Thresholds between Philosophy and Psychoanalysis', FAB, London 1989. She was honorary secretary of the UKCP.

Miranda Passey, BA, CQSW, MACP, is Principal Clinical Psychotherapist on the Isle of Wight. She trained at the Tavistock Clinic and has a particular interest in developing awareness of the work of Child Psychotherapists

in order to reach a greater number of children in difficulties than is at present possible. As well as her work in the Health Service, she works in a school for children with speech and language difficulties.

Michael Pokorny, MB, ChB, DPM, FRCPsych., Member Brit. Psi.-An. Soc., trained in medicine and psychiatry before training in psychoanalysis and psychoanalytic psychotherapy with adults: individual, group and marital. He was Chair of the Rugby Psychotherapy Conference Working Party from 1982 until the inauguration of the United Kingdom Standing Conference for Psychotherapy in 1989. He was elected Chair of UKSCP annually from 1989 until 1993, when he was appointed to be the first Chair of the Registration Board of the United Kingdom Council for Psychotherapy. He is in full-time private practice as a Psychoanalyst and Psychotherapist with a special interest in conjoint marital psychotherapy.

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Kenneth Kirk Smith, MA (Oxon), Dip. App. Soc. Stud. (London), read law at Brasenose College, Oxford, and after two years Voluntary Service Overseas in India, trained to be a social worker at Bedford College, London. In 1967, he began to work with the London Probation Service at the Old Street Magistrates Court in Hackney. In 1970, he became a child-care worker in Barnet. After the local government re-organisation following the Seebohm Report, he spent a year at the Tavistock Clinic on the full-time social work course. After this, he worked for the Family Welfare Association for ten years, and for Wandsworth Social Services for a further eight. Facing another reorganisation, he took early retirement,

and spent a year at the LSE as a social worker with a group of people researching new religious movements. He now works with the Church Army as a social worker, at the Marylebone Project which is in the forefront of the problem of homelessness. He is a member of BASW, and was chair of GAPS for six years. He is treasurer of the United Kingdom Council for Psychotherapy.

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Jenifer Elton Wilson, BA, MSc, is a Chartered Psychologist whose work as a psychotherapist has been focused on the recent establishment and provision of counselling psychology within the UK. Having both studied and taught counselling psychology at Master's level, she is currently Head of an expanded counselling service at the new University of the West of England, Bristol. She is Chair of the British Psychological Society Special Group in Counselling Psychology. Her main interest is in the interface between personal meanings and the impossible struggle for excellence in the practice of psychological therapy.

Preface

Petrūska Clarkson and Michael Pokorny

THE BACKGROUND

From our differing but complementary backgrounds, we have shared the idea of a *Handbook of Psychotherapy* for some time. As far back as 1990, Bob Hinshelwood was prescient by linking our two names together in working to push forward the frontiers of psychotherapy in our respective ways. In an editorial of the *British Journal of Psychotherapy*, he wrote:

> If the Standing Conference (UKSCP) shows signs of cohering into a proper professional organisation at last it is because of years of cool (though sometimes impatient) debate. The Conference has become a forum where those who would never normally feel inclined to speak to each other have sat down and shared passionate hopes together. Michael Pokorny's letter, as chairman of the Conference, marks steady progress in the political organisation of psychotherapy in this country and in Europe.
>
> Politics is one thing: perhaps, however, we are still a long way from a similar engagement over differences of theory and practice. However Petrūska Clarkson's careful analysis of the various levels of the psychotherapeutic relationship is an attempt to find a perspective from which an overview might become possible. She contends that all therapeutic relationships have five levels even though the different psychotherapies prioritise different levels. This offers a way of circumventing the inherent contradictions and incompatibilities that exist between different psychotherapies; instead of compatibilities we have different priorities and emphasis. And this leaves a way open for the beginnings of a possible integration of the psychotherapies.
>
> (Hinshelwood 1990: 119)

Although the idea for this book was first mooted by Routledge to Petrūska in 1989, it has taken several years to come to maturity. It was when Michael Pokorny joined as co-editor that a dialogic relationship was formed which provided the necessary impetus for carrying it to completion.

The original idea for the *Handbook* was to provide a reasonably comprehensive overview of the field of psychotherapy which was accessible enough to the intelligent lay person; as well as useful enough for people who may wish to use or refer in terms of these services (such as general practitioners, social workers and employers), and serious enough to be interesting to practitioners, trainers and supervisors in the field of psychotherapy.

THE *HANDBOOK*: BACKGROUND

The *Handbook* is divided into five parts: Introductions, Culture, Modalities, Settings and Issues. The three chapters in the introductions series constitute a scene-setting: first comes 'The nature and range of psychotherapy', which surveys (1) the different professions involved in this field such as counsellors, psychotherapists and counselling psychologists (differentiating them from adjacent disciplines), (2) the three different ideological traditions or 'schools' in psychotherapy, and (3) presents a map for conceptualising the different modalities of psychotherapy. The second chapter is a version of the paper 'The multiplicity of psychotherapeutic relationships'. It is this paper which first appeared in the *British Journal of Psychotherapy*, and which Hinshelwood introduced above as having 'the potential for the beginnings of a possible integration', or at the very least a framework within which to begin to communicate across the inevitable schisms, suspicions and territorial disputes of different schools. Even at the end of this book it became clear that, throughout most of the chapters, there was a constant implicit, if not explicit, awareness and exploration of the importance of the therapeutic relationship.

Contrary to the usual procedure of putting the research chapter last, or towards the end, we acceded to the request of Wilson and Barker to position the research paper near the beginning as the third chapter. This chapter could, in addition to the relationship paper, act as an initial prism to highlight a perspective through which to view all the chapters that follow, rather than being an afterthought.

We believe that cultural issues in psychotherapy have been significantly neglected compared to theoretical disputations, and that the influence of such factors is vastly underrated in many of the approaches to psychotherapy that tend to be Eurocentric, patriarchal and limiting. That is why cultural issues are separately grouped in Part II of the book. Here, from her vast experience, Grant explores some of the issues of psychotherapy and race. Ernst and Gowling, from their different perspectives, address the influence of gender on psychotherapy – the counter-transference issues which are so enormous that none of us, however conscious, can consider ourselves free from the pernicious influences of the sexism that has pervaded the theory, practice and management of psychotherapy. In

Chapter 6, Hassan discusses her work – the result of another of our culture's most penetrating abuses. This is particularly relevant at the time of writing as we read reports, for example, about ethnic cleansing in Bosnia. Hitchings then offers a view of the issue of sexual orientation as it affects psychotherapy.

In Part III, Modalities, Pokorny and Lister-Ford survey the field of individual adult psychotherapy in Chapter 8, with a brief glance at some of the therapeutic orientations. It must be said that this book, contrary to some excellent others, has attempted to underplay the emphasis on difference between schools and to emphasise common themes and concerns across schools. Harper gives an overview of the spectrum of psychological therapies with children, and Passey surveys the field of analytical psychotherapy with children, while Jezzard gives another perspective on psychotherapy with adolescents culled from his own rich experience. Butler and Low give, jointly and severally, two of the many perspectives on short-term psychotherapy; Leary and Walton briefly but effectively discuss marital psychotherapy. Gorell Barnes and Cooklin skilfully review family psychotherapy, followed by Manor's contribution of a perspective on group psychotherapy of different orientations.

Part IV concerns settings. Psychotherapy in and with organisations brings together the work of Hawkins and Miller, whereas Kosviner expertly reviews the state of psychotherapy within the NHS, with additional material from Knowles. The two Smiths look at the place of psychotherapy in the social services, whereas Oakley and Millard contribute a wide-ranging theoretical perspective on psychotherapeutic communities. Llewellin uses the contributions of several colleagues to bring together her chapter on psychotherapy in the voluntary sector, while Pokorny and Fanning discuss some of the issues of psychotherapy in private practice, with additional material from Hargaden.

Part V concerns recurring and significant current issues in psychotherapy. Bungener and McCormack explore the relatively neglected area of psychotherapy and learning difficulties; Embleton and Tudor, some aspects of the roles of power and influence in psychotherapy – the subject of a number of current conferences. Bentovim and Tranter describe the very important sector of psychotherapy with adult survivors of sexual abuse. This is followed by a chapter on its professional corollary – sexual contact between psychotherapists and their patients, in which Garrett gives a preview of her research. Alon and Levine Bar-Yoseph draw on their experience of post-traumatic stress disorder, and Welldon surveys the less well-known but significant field of forensic psychotherapy. Finally, and fittingly, the book ends with the chapter by Parkes and Sills on psychotherapy with the dying and the bereaved. Two appendices follow – the structure of the United Kingdom Council for Psychotherapy and its member organisations, and the UKCP Code of Ethics.

It is definitely not expected that this book will be read from start to finish, but rather that it will become a useful resource for professionals and lay people alike, beginners and experts, in opening or re-opening doors to areas of interest, learning and professional growth.

With many of the chapters, the authors and/or editors have adduced sources, contact addresses and further reading lists in addition to the usual references. We apologise for no doubt numerous omissions, but wanted to indicate some rather than be exhaustive. For the interested inquirer just beginning a search into a particular area, contacting or reading a couple of sources can often act as a key to unlock the riches which are available but sometimes difficult to access. Information on training is also available from any one of the UKCP member organisations.

The authors in this *Handbook* are an unrepresentative cross-section of the field as it exists today, based on the response we elicited from practitioners able and willing to write within the time limits at our disposal. Each chapter should therefore not be seen as a definitive statement: the diversity of styles and approaches illustrates a sampling of the wide diversity of the voices in the field. Our aim was to have more than one author speak on each subject where possible; this way, the reader benefits not only from two expert perspectives, but from the creative tension that can emerge from all such dialogue. The final collection is not intended to be representative of all themes, modalities, settings and forms of psychotherapy. In many cases we did ask colleagues to contribute and they could not join the project in time. The authors finally represented here are the outcome of a long and frequently fraught process of contacting authors who promised and did not deliver, who backed out at the last minute, who stepped into the breach, who delivered promptly and with good humour, who forgave our occasional mistakes with good grace, and those who showed some care and concern for our responsibilities and for us as people.

Diversity is an integral and important element of psychotherapy in the United Kingdom and we are proud to carry this flag into Europe and the wider world. It is an integral phenomenon of the English-speaking world to tolerate idiosyncrasy, celebrate difference *and* maintain professional standards. The diversity in this book, we hope, reflects and respects the multitudinous differences that exist among the human beings who come to us for help.

Where clinical material is used for illustration by any author, details have been changed to ensure anonymity. The responsibility for clinical material belongs to the author(s) who have written it, as does the responsibility for permission to reproduce material in the form of extended quotations or diagrams. Despite research showing that no single school has 'all the answers', as mentioned in several chapters (such as 2 and 3), most psychotherapists adhere to a particular orientation, even if it is their one version of the integrative psychotherapies. Authors will therefore refer to

people who seek help from psychotherapists, sometimes as patients and sometimes as clients.

The views expressed in these chapters are the view of the authors and not necessarily of the editors. We have also used the terms 'he' and 'she' interchangeably for both the psychotherapist and client in order to try to maintain a balance.

We wish you *bon voyage*.

REFERENCE

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Part I

Introduction

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Chapter 1

The nature and range of psychotherapy*

Petrūska Clarkson

A chapter of this length cannot fully do justice to the ongoing debate about the nature and range of psychotherapy. It is a subject which continues to exercise some of the finest minds active in psychotherapy today, as witness both the mainstay texts in any training course in counselling and psychotherapy, and the current debate in specialist journals.

In the first instance, definitions of psychotherapy will be briefly reviewed. This will be followed by an attempted differentiation between the major professions engaged in counselling and psychotherapy, following closely the conventions of the main professional bodies involved. The third section will concern a review of the major traditions in psychology which have given rise to different approaches, and briefly review the significance of research in this field. Lastly, there is a diagram for differentiating between different modalities or arenas for counselling and for psychotherapy.

DEFINITIONS

Definitions of psychotherapy are legion, and none is entirely comprehensive nor entirely satisfactory.

> Legislators and courts of law have found it almost impossible to define 'psychotherapy' in such a way as to include, by universal agreement among therapists, that which *is* psychotherapy and to exclude that which *is not* psychotherapy.
>
> (Watkins 1965: 1142)

In their textbook of psychiatry, Henderson and Gillespie (1956) regard psychotherapy as any therapy of the mind, appearing to include talking treatment alongside insulin coma in their fifth edition of 1940 but, by their

* The author wishes to thank Michael Carroll for his valuable editorial input, and for providing the definition of counselling psychology; also Michael Pokorny for his additional material. A portion of this chapter is from 'Counselling, psychotherapy, psychology and applied psychology: the same and different', by P. Clarkson with M. Carroll, in P. Clarkson (1993) *On Psychotherapy*, London: Whurr.

eighth edition of 1956, psychotherapy has become specific to psychoanalysis and its derivatives. Mayer-Gross *et al.* (1954) do not offer a general definition of psychotherapy but use the term to cover a variety of talking treatments. They seem to distinguish it from psychoanalysis as well as from behaviour therapy. They regard all forms of physical treatments as quite separate and different. Merskey and Tonge (1965) clearly regard psychotherapy as talking treatment.

Holmes and Lindley offer a definition: 'The systematic use of a relationship between therapist and patient – as opposed to pharmacological or social methods – to produce changes in cognition, feelings and behaviour' (1989: 3). Notice that the use has to be systematic. Holmes and Lindley go on to consider forms of psychotherapy under the headings of structure, space and relationship. Another idea is that psychotherapy is the treatment of psychological conflicts no matter what the presenting symptoms are.

All these definitions rely on the idea of bringing about changes in the personality and manner of a person's relating by the use of essentially psychological techniques. If we are to cover all forms of psychotherapy, that seems to be about as definite as we can get. As soon as we try to be more specific, we begin to exclude some therapies. Of course we may wish to exclude some therapies. There is no agreement on the exact boundaries of psychotherapy. One result of this is that the political definition of psychotherapy has given rise to great argument and considerable tensions within the profession. I refer to the process by which the United Kingdom Council for Psychotherapy (UKCP) has come into being from the original Rugby Psychotherapy Conferences, via the intermediate stage of the UK Standing Conference for Psychotherapy. It is possible to define psychotherapy as all those therapies that are recognised by the UKCP. That is a simple way of reaching some sort of agreement. The trouble is that there are always some who claim that some psychotherapy is excluded from the Council. This is merely another way of having the argument of what is, and what is not, psychotherapy. On the other hand we can recognise that other professions also have ill-defined borders, and we can stop worrying so much about our general definition or our political solution by recognising that the borders of psychotherapy are not fixed.

The time-span within which psychotherapy operates ranges from one interview to many years of treatment. The rise of brief psychotherapy (as discussed in Chapter 11) has shown that not only can important changes be made very quickly, such as in ten or fifteen sessions, but can also occur within just one interview. The time boundaries of group psychotherapy have proved to be very varied. From a start of once-weekly group meetings lasting one-and-a-half or one-and-a-quarter hours, groups have become marathon, intermittent, more than once a week; the variations that have been tried out seem endless. Once the psychotherapy is exported to the home setting, as can happen in some family therapy clinics, the time frame

changes altogether, lasting until something is achieved, or the team has to leave. Even in the psychoanalytic sphere there has been change. In some places analysis takes place five times per week, in others four or three times weekly. Even more radical, the revolutionary French psychoanalyst Lacan would end the session when some significant moment had been experienced. Thus sessions could last for ten minutes or two hours.

In many psychotherapies a contract for time and fees is made at the start, although it may have to be modified later. Even where the contract appears not to have been made overtly, as in psychoanalysis, in reality the contract is for as long as it takes, even if that is many years. Of course in a therapeutic community the time involved is twenty-four hours a day for many weeks, months or years.

The range of clients that are offered psychotherapy has varied from time to time and from place to place. There seems to be general agreement that neurotic symptoms are amenable to psychotherapy, and there is so far no clear evidence that the form of the psychotherapy makes a material difference to the outcome. Other diagnostic categories, or the psychotherapy from which they draw, produce very different reactions from different psychotherapists. There are therapeutic communities that specialise in treating psychosis, such as the Arbours Association and the Philadelphia Association, both being descendants of the original work of Laing. Some psychotherapy schools seem to specialise in certain types of client, so that, for instance, specific phobias have become largely the province of behaviour therapy, especially the implosion treatment for phobia of spiders (arachnophobia). Others have specialised in the treatment of psychopathy, especially the Henderson Hospital, and yet others in the treatment of offenders, such as the Portman Clinic for sexual offenders and Grendon Underwood prison which has an excellent record in the rehabilitation of recidivist criminals using a combination of community and group methods, including psychodrama. The validation of results, psychotherapy studies or outcome (as discussed in Chapter 3) is another matter of great concern to us all. It is hoped that the new moves towards psychotherapy audit will help on this front.

ALLIED DISCIPLINES

This section considers some of the factors involved in differentiating counselling, psychotherapy, psychology, psychiatry and several allied fields. It is written for several reasons. One is to help establish for counsellors, psychotherapists and counselling psychologists separate and valuable professional identities which have a place and domain of their own. Such an attempt can provide helpful guidelines for referral agencies, professionals and members of the public to distinguish between different kinds of service provision, so that needs and resources can be more

accurately aligned. Ignorance and confusion in themselves further perpetuate difficulties endemic to the most complex task of providing the best and most cost-effective help for individuals in emotional trouble, with the least long-term detrimental effects, and hopefully of most benefit in terms of improved psychological health. Secondly, the ability to know where helping modalities overlap and where they differ can be a tremendous help to professionals themselves. It can establish boundaries, acknowledge strengths and limitations and afford a working relationship between them that fosters mutual respect rather than distrust. Professionalisation, accreditation and ethical sanctions can go some way towards reducing potential damage: they can also provide the first step towards professional identity and the ability to relate to other professionals from similar and different helping backgrounds.

According to Carroll (1991, 1992b), there are three main approaches to considering the relationship between counselling, psychotherapy, psychology and psychiatry.

First, there are those who 'lump them together' and refuse to acknowledge any differences. They point dramatically to the client groups dealt with by each profession and hail the fact that counsellors see clients, psychotherapists see clients (but they may call them patients) and counselling psychologists see clients (they call them both clients and patients) and that these clients do not differ substantially from one another. Domains held sacred by one profession are invaded without apology by another. Psychotherapists see clients in long-term therapy, some of whom are very disturbed and difficult people who may even have psychiatric histories and they may work with transference and the unconscious. Such very disturbed clients traditionally have been the work of the psychiatrist, the clinical psychologist, or the psychotherapist. The counsellor, on the other hand, sometimes works in a college of higher education, can average six sessions a client and deals with crisis and developmental issues. The counselling psychologist (a new breed on the British scene) works in hospitals, organisations, mental health centres and all those areas once claimed by counsellors, psychotherapists and clinical psychologists. Why try to fabricate differences if all three approaches do much the same thing?

According to Carroll, a second group 'split' the groups and refuse to acknowledge many similarities. Counsellors, they claim, are low on theory, have no requirement for personal therapy in their training, work in the short term and with developmental issues. Counselling psychologists are psychologists who use counselling in their work, are high on theory and research and as yet seem unsure about where they will end up or in what client groups they will specialise. Psychotherapists concentrate on personal psychotherapy, use supervised client work, spend a long time as apprentices, and have deeply disturbed and long-term clients. However you view it, these are three different approaches to helping people and proponents

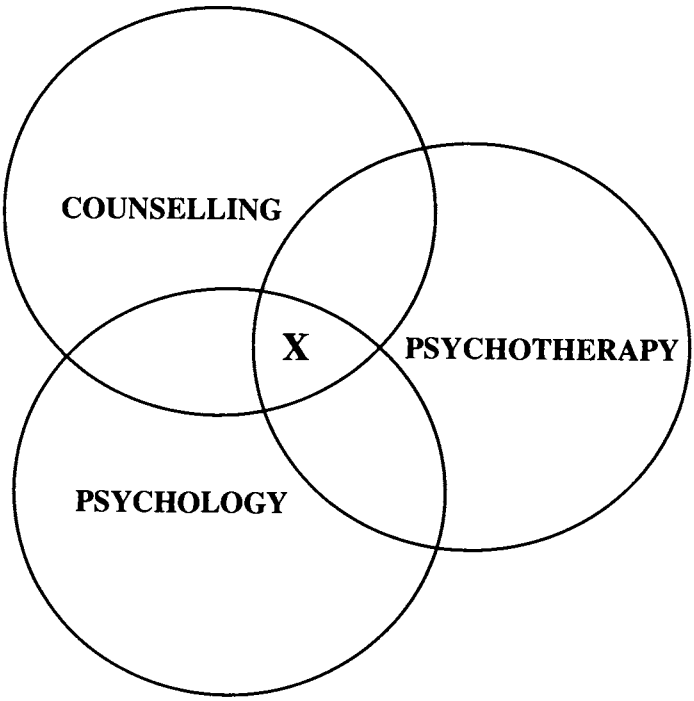

Figure 1.1 Venn diagram representing the three primary arenas of counselling, psychology and psychotherapy

of this view believe they must be kept separate. Some view the differences in terms of specialisation, others in terms of training. It is also true that issues of power, ideology, money, status, employability and snobbery play a significant part in such territorial anxieties.

A third group talk about 'overlap' between the three: areas of similarity and areas of difference. Duffy (1990: 11) recognises the areas in common and sees differences coming from 'intentionality'; that is, not what is done but how practitioners think of their work. This contribution of Carroll is supplemented here by a diagram (Figure 1.1), which I developed to illustrate the discussion. Figure 1.1 is offered as a potentially helpful tool in guiding and demarcating the discussion areas between the overlapping fields of counselling, psychology and psychotherapy and will form the basis for the discussion in the rest of this section.

Figure 1.1 shows each area as distinct in itself, but relating to each of the other two areas, and indicates the interrelationship between all three. The overlap area between counselling and psychotherapy represents the work of counselling professionals with advanced practice qualifications or the psychotherapist using counselling skills. The overlap area between psychotherapy and psychology represents psychotherapists with a psychology

qualification or psychologists trained as psychotherapists. The overlap area between counselling and psychology represents counselling psychologists – that is, psychology graduates with counselling qualifications, but no special training in psychotherapy. 'X' marks the area of work which involves the work of psychology graduates who have training and experience in both counselling and psychotherapy. This may be the appropriate area for the profession of counselling psychology.

We will look in detail at each of the above – namely, the counsellor, the psychotherapist and the counselling psychologist – and then note four areas where dialogue can take place between the three approaches. For each profession, people can be self-referred, or come via their general practitioners, friends or contacts.

Counsellor

The British Association for Counselling, founded in 1977, defines counselling as follows:

> Counselling is the skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth, and the optimal development of personal resources. The overall aim is to provide an opportunity to work towards living more satisfyingly and resourcefully. Counselling relationships will vary according to need but may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insights and knowledge, working through feelings of inner conflict or improving relationships with others.
>
> The counsellor's role is to facilitate the client's work in ways that respect the client's values, personal resources and capacity for self determination.
>
> (BAC 1989: 1)

Counsellors may bring special training, experience and expertise to the counselling relationship, to enable people to further their own growth and enhance their personal functioning. In this way, counsellors are enablers and facilitators, helping a client with a specific problem and focusing on evolutionary change. Counselling is largely a general field, but it can also be quite specific; for example, redundancy counselling, marital or sexual counselling, debt counselling, HIV, retirement and health counselling, or bereavement counselling.

The British Association of Counselling publishes a directory of counsellors throughout the United Kingdom. This body also has a Code of Ethics and Practice for Counsellors, whose aim 'is to establish and maintain standards for counsellors and to inform and protect members of the public seeking their services'. Also under this code, 'counsellors subscribe to

principles in the areas of (1) the nature of counselling, (2) issues of responsibility, and (3) issues of competence' (BAC 1984: 1).

Counsellors may be eligible for accreditation through the BAC, which has a Counselling at Work Division as well as a Personal, Family, Sexual and Marital division, a Division for Pastoral Counselling, Counselling in Education and one for Counselling in Medical Settings. Training in counselling is usually one to three years, although some people who become counsellors have no other qualifications than experience and expertise. Counsellors often argue, sometimes with good reason, that they do psychotherapy, as there is much overlap between the two areas. A well-trained counsellor may do work of equal value to that of people in other fields. Their focus, however, is *likely* to remain with more short-term work, with the less seriously disturbed members of the population, and with areas of life adjustment such as bereavement or career counselling or crisis support, guidance and problem-solving rather than in-depth work on a person's childhood. The task of counselling is to give the client an opportunity to explore, discover and clarify ways of living more satisfyingly and resourcefully. Counselling is thus not a destructuring and restructuring of personality, but aims to create the conditions through the counselling relationship wherein a person can connect with their basic drive towards health, and be enabled in adjusting to changes of role situations and developmental states in life. Counsellors usually do not have psychology degrees and thus do not consciously use psychology as an academic discipline as a basis for their practice. Pastoral counselling centres (for example, the Westminster Pastoral Foundation) more usually train counsellors in psychodynamic theory and practice.

It seems at this stage best to serve the two areas, counselling and psychotherapy, by concentrating on where they are most different; that is, highlighting the polar opposites, rather than getting stuck in a quagmire of overlap. Counselling can be seen to focus on evolutionary change, whereas psychotherapy focuses on revolutionary change. Proctor (1989) writes about person-centred problem solving in the here-and-now. Difficulties in distinguishing between counselling and psychotherapy do not absolve us from responsibility to look at the poles. Issues become clearer when we look at the two poles; and just because the task is difficult does not mean it shouldn't be done. Doing this, we can establish whether an issue is closer to one 'end' or the other. This is easier and more effective than trying to make a boundary, because clearly there is considerable overlap.

Counsellors help to oil the wheels of someone's experience so that they manage to function better. It is meant to alleviate suffering. It is for those whose life position is comfortable enough so that they could get through life very well without a 'metanoia' or a turnabout. Counselling seems most suited to a model of human growth in human beings, and indeed many

counselling courses are predicated on the work of Rogers, who emphasised that, through the creation of the necessary conditions of respect, empathy and genuineness, the human being will naturally learn

> to *be* more of his experience – to be the feelings of which he has been frightened as well as the feelings he has regarded as more acceptable. He becomes a more fluid, changing, learning person . . . the motivation for learning and change springs from the self-actualising tendency of life . . . to flow into all the differentiated channels of potential development, insofar as these are experienced as enhancing.
>
> (Rogers 1961: 285)

A characteristic of revolutionary change is that the starting conditions and basic components of the system have to be changed, and may even appear out of the regions of probable predictions. Evolutionary change, in contrast, suggests that the same starting conditions and basic components can conceivably lead to the accomplished outcomes; that is, one could predict the range of probable outcomes. The juxtaposition of evolutionary and revolutionary change emphasises different sets of skills, different goals and different methodologies. An individual's defensive structures can be left intact or strengthened in counselling, by using existing personality resources and the individual's potential for growth and self-healing.

Psychotherapy, on the other hand, focuses on discontinuous, revolutionary change. The justification for psychotherapy often needs to be that such an expensive and time-consuming intervention is necessitated because, unless discontinuous change is implemented, serious tragedy may result. In this case, the medical model may be appropriate in terms of diagnosis (or at least assessment) leading to treatment implementing or seeking for a 'cure'. A medical model may be more effective when there is actual structural damage to the organism which has to be reversed before the organism can start reconnecting with its own innate healing process. Psychotherapy, whether psychodynamic, behavioural or humanistic/existential, concerns the destructuring and restructuring of the personality, whether it is conceived of as belief-and-behaviour systems, ego states, or super-ego and self structures.

Sometimes counsellors lack the training and the facilities in screening, assessing and monitoring risks of suicide, homicide or psychosis which may only become apparent in the later stages of a helping relationship. Of course, this is not to suggest that all screening or assessment procedures, even when done by extremely experienced psychotherapists or psychiatrists, are always either effective or helpful. On the other hand, there are many reports of well-functioning individuals who set out to find someone to help them with a circumscribed problem such as a lack of interest in sex with a marital partner, and then end up several years later,

having entered (for example) three-times-weekly psychoanalysis, with a sense of having been misled or misinformed. The point here is not to suggest that there are absolute dividing lines between the work of the different professions, but to engage others (in and outside these professions) to continue to question and articulate what differences there may be; not so much in the overlap areas, but in the areas which are more distinctly differentiated.

Loughley (1985), during a conference on training in counselling and psychotherapy, put it this way:

> Counselling and psychotherapy are not the same process, although I know there are some of you who would disagree with that statement. For me the difference between them is one of history. Counselling focuses on that which belongs to the now-here. It can be achieved through care and cognition, it is possible to think about it. Psychotherapy on the other hand, is to take the now as a living history: that the things learnt then are happening now but in a different context.

Counselling therefore can be seen to focus on *enabling* and *facilitating*, whereas psychotherapy can be seen to emphasise *intervention*, *treatment* and *reconstruction*. Given that in evolutionary change the organism is striving, naturally and probably successfully, towards its fulfilment, the helper needs to be supportive, enabling and facilitating of this self-generated and self-directed process. In revolutionary change the focus is on interpretation, confrontation, destructuring and reconstruction. The risk of systemic disintegration is naturally lesser in evolutionary change than in revolutionary change, and therefore the skills and experience involved in the latter are naturally of a different order; but not necessarily better or worse than the skills of enabling or facilitation. Goal-setting and the educational task will therefore be more important in counselling training, and diagnosis of pathology more important in the training of psychotherapists.

It is less differentiating but, practically, still the case that counselling assists people in finding the solution to a particular problem, or dealing with a particular crisis, whereas psychotherapy helps people to develop new ways of solving problems which can become generalised to new situations. There is also sometimes, as with Loughly above, a differentiation drawn between counselling as dealing with a current situation contrasted with psychotherapy as dealing with a past situation.

Psychotherapist

Psychotherapy can also be defined as:

> a form of treatment for mental illness and behavioural disturbances in which a trained person establishes a professional contact with the

> patient and through definite therapeutic communication, both verbal and non-verbal, attempts to alleviate the emotional disturbance, reverse or change maladaptive patterns of behaviour, and encourage personality growth and development. Psychotherapy is distinguished from such other forms of psychiatric treatment as the use of drugs, surgery, electric shock treatment and insulin coma treatment.
>
> (Freedman *et al.* 1975: 2601)

> Psychotherapy is the treatment by psychological means of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with a patient with the object of removing, modifying or retarding existing symptoms, of mediating disturbed patterns of behavior and of promoting positive personal growth and development.
>
> (Wolberg 1954: 118)

Previously, anybody could set up as a psychotherapist: that is, prior to the formation of the UKCP, whose aim is to create a profession and a register so that the public can identify appropriately trained practitioners who are subject to an enforceable Code of Ethics. It was founded as the UKSCP in 1989, is now the UKCP and has seventy-three member organisations grouped into eight sections, each containing a distinct kind of psychotherapy (see Appendix A for details). The voluntary Register, which appeared in May 1993, will form the foundation of a Statutory Register of psychotherapists. A national audit of psychotherapy is in preparation and a variety of initiatives are under way, including co-operation with the development of national vocational qualifications at the higher levels, research into and management of the overlap between psychotherapy, counselling and counselling psychology.

There is now usually a minimum of three years' training, and most psychotherapy training institutions involved in the UKCP require most of their trainees to be in extended personal psychotherapy so that professionals who graduate from these training programmes have personal experience of the process and uses of psychotherapy themselves. Thus, personal psychotherapy is considered to be a vital part of most training. The personal psychotherapy of trainees usually is of a similar duration, type and frequency as that which they would be offering their clients.

Psychotherapists would expect to deal with more serious problems, such as clinical aspects; clients are seen frequently, in regular sessions at least once a week, perhaps more frequently. Clients (or patients) may want to go deep and far back into their past; repetitive patterns of behaviour are identified, worked on and cleared if they are having a negative effect upon the client's present life. Psychotherapists will usually have a wider range and greater flexibility in their working methods than counsellors or psychoanalysts. Psychotherapists may or may not be psychoanalysts.

Psychoanalyst

Freud gave several definitions of psychoanalysis. One of the most explicit is to be found at the beginning of an encyclopaedia article written in 1922:

> Psycho-analysis is the name (i) of a procedure for the investigation of mental processes which are almost inaccessible in any other way, (ii) of a method (based on that investigation) for the treatment of neurotic disorders and (iii) of a collection of psychological information obtained along those lines, which is gradually being accumulated into a new scientific discipline.
>
> (Laplanche and Pontalis 1988: 367)

> The word 'psychoanalysis' refers to a theoretical viewpoint concerning personality structure and function, in the application of this theory to other branches of knowledge and also to a specific psycho-therapeutic technique. Although much developed since his time this body of knowledge is based upon the discoveries of Sigmund Freud.
>
> (British Psycho-Analytical Society 1990: 37)

Psychoanalysts may or may not be medical doctors; but all psychiatrists are medically qualified. Psychoanalysts have recently organised themselves into a body called the British Confederation of Psychotherapists.

Psychiatrist

The Shorter Oxford Dictionary defines psychiatry as 'healing, medical treatment. . . . The medical treatment of diseases of the mind' (Onions 1968: 1700). The relevant professional body is the Royal College of Psychiatrists. Psychiatrists have a medical degree, then undergo further specialist training in psychiatry. Many psychiatrists are not trained in psychotherapy, but they can prescribe drugs. There is a clear difference between child and adult psychiatry. Psychiatrists are specialists in the treatment and management of serious disturbances such as psychosis, schizophrenia, manic-depressive disorders and so on. They tend to work in hospital or psychiatric settings, unless they work in private practice settings.

Psychologist and applied psychologist

Psychologists and applied psychologists are another category to be distinguished. Psychologists are professionals with at least one degree in psychology. Many move on to further postgraduate studies in applied psychology, one of which, these days, is counselling psychology.

The dictionary definition of 'psychology' as 'the science of the nature, functions and phenomena of the human soul or mind' (Onions 1968: 1700)

is somewhat restrictive in its view. Psychology is not only the 'science of the mind' but also the science of human behaviour in all its aspects. Psychology interprets the person (Carroll and Pickard 1993) and results in a number of theories of personality and research methods for understanding the person. Its questions are person-related: why do people behave the way they do? What motivates the individual? How do people grow and begin to think and use language? Can we isolate stages of life as individuals progress towards old age? From its academic base, psychology is divided into a number of subsections, such as development psychology, cognitive, personality theory, biological basis of behaviour, abnormal psychology psychological assessment. From this academic basis, psychologists move to apply their subject to the world.

The British Psychological Society is an amalgamation of the various applied psychologies. There are approximately thirteen Divisions, Sections and Special Interest Groups within the Society, ranging through developmental psychology, educational, occupational, clinical, counselling, clinical neuropsychology and so on. It can be difficult at times to differentiate between the three: the occupational psychologist, the clinical psychologist and the counselling psychologist.

Occupational psychologist

An occupational psychologist will have knowledge in relation to the following eight areas: 'Human-machine interaction, design of environments and of work, personnel selection and assessment, performance appraisal and career development, training (including identification of needs and evaluation), employee relations and motivation and organization development' (Fitzgibbon 1990).

Not many occupational psychologists train to do psychotherapy. Occupational psychologists are usually better paid than clinical psychologists, since they usually work in industry (as opposed to the NHS), and they may, for example, work on computers to make software programs.

Clinical psychologist

'The key tasks of clinical psychologists are: Assessment, Treatment, Training/teaching and Research (both patient and service related) as well as Management' (BPS 1988b: 4).

All clinical psychologists must belong to their professional body, the British Psychological Society, and they will then be on the Register of Chartered Psychologists. This document is available from the BPS, and it contains the names, qualifications and contact addresses of all the chartered psychologists in the United Kingdom. The BPS distinguishes between members who are prohibited from using MBPsS on publicity (BPS

1991: 26–27), and chartered psychologists who have done additional training in psychology in addition to holding a psychology degree.

A clinical psychologist will have studied psychology for a long time (usually a bachelor's and often a master's degree in psychology), and will have trained in clinical settings; for example hospitals, with clinical focus, or made special study of mental retardation, or management of phobias or behaviour disorders. Not all chartered clinical psychologists are trained in psychotherapy; many have not been in psychotherapy themselves. They do not prescribe drugs, but they are usually trained to do psychodiagnostics, such as the use of tests such as the Rorschach, Myers Briggs, MMPI or Wechsler.

> The range of treatment techniques has grown considerably during the last twenty years, from the previously limited range of essentially educational or psychodynamic techniques. . . . Examples are the treatment of elimination disorders in children, phobic conditions in adults and the remediation of cognitive difficulties following different types of brain injury. Some of these treatments now offer positive alternatives to drug treatments (such as anxiety-management procedures), and supplement medical treatments in people with long-term-disabling conditions.
>
> Behavioural methods (such as desensitisation), methods based on social learning principles (such as social skills training) and cognitive methods, used especially for altered mood states, are now widely used. In addition, a wider range of psychotherapeutic approaches has been developed, based on theories that are not essentially psychodynamic (such as personal construct theory). It has become apparent that there are a number of non-specific factors which are relevant to many apparently different techniques. A number of these approaches are used by counsellors and other non-psychologists to help people with less serious conditions.
>
> (BPS 1988a: 5)

As said before, 'the boundaries between clinical psychology as a discipline and other academic and health-care disciplines, are not fixed' (BPS 1988a: 1), and the development of the profession of counselling psychology demonstrates this further.

Counselling psychologist

Training as a Counselling Psychologist is already an avenue to chartered psychologist status and the group may soon become an independent Division of the BPS. At the time of writing it is a Special Group of the BPS, as Carroll makes clear:

> counselling psychology moved from being a 'Section' in 1982 to becoming a 'Special Group' in 1988 with increasing aspirations to becoming a Division within BPS. Its membership . . . is still probably the fastest-growing section of the BPS. . . . Becoming a Division with BPS would bring with it major implications for training, training courses, career structure and pay levels, status, and supervision. A proposed new Diploma in Counselling has been outlined as the next step on the journey to Division status.
>
> (1991: 74)

One important, if not the most important, difference between counsellors and counselling psychologists is the conscious use of academic psychology alongside practical counselling skills. Counselling psychologists have a basic degree in psychology, and then further training in counselling psychology (MSc). Counselling psychology is here conceptualised as the overlapping area between counselling and psychotherapy in the Venn diagram (see Figure 1.1 above) representing the three primary arenas of counselling, psychology and psychotherapy.

Counselling psychology is not considered identical with counselling (even when it is carried out by psychology graduates). In counselling psychology, there is an emphasis on the systemic application of distinctively psychological understanding, based on empirical research of the client and the counselling process, to the practice of counselling. The relevant psychological knowledge is partly concerned with the problems of presenting clients, and partly with the procedures and processes involved in counselling. It would be remembered that counselling psychology involves work in an organisational context as well as with individual clients, and synthesises elements of better-developed areas of professional work such as clinical and occupational psychology. Life-span developmental psychologies, and the social psychology of interpersonal processes are among the areas that supply the academic foundations of counselling psychology. Of central scientific relevance, of course, are empirical investigations of the processes and outcomes of counselling and of related methods of psychotherapy.

> The psychological understanding of counselling derives not only from formal psychological enquiry but also from the *interpersonal relationships* between practitioners and their clients. The essence of such relationships is one of personal exploration and clarification in which psychological knowledge is utilized and shared in ways which enable clients to deal more effectively with their inter- and intra-personal concerns. The capacity to establish and maintain such relationships ultimately rests upon the personal qualities and maturity of the individual counselling psychologist. Personal qualities such as non-defensiveness and a capacity to experience and communicate empathic resonance, constitute essential

> resources which the counselling psychologist draws upon. Whilst these characteristics may be enhanced by skills training they derive primarily from a foundation of personal experience and integrative maturity.
> (BPS 1989: 1; author's italics added)

Emerging issues

From the above, a number of interesting areas emerge as crucial to the ongoing dialogue of exploring, differentiating or ignoring professional disciplinary boundaries.

First, the concept of change and what it means. There are different kinds of change possible within therapeutic settings: problem-solving, environmental change, adjustment, renegotiation (as in a relationship), developmental change (evolutionary) and revolutionary change (personality restructuring). Is it possible to look at the professional approaches above to see if certain approaches are more appropriate for certain kinds of change within the person and his/her environment?

A second area of interest is the area of relationship within therapeutic settings. Clarkson (1991) and Gelso and Carter (1985) have outlined different kinds of relationships appropriate to different therapeutic approaches or more applicable to different client groups. It may well be that such relationships are also in keeping with the professions above.

The third area is that of training. Carroll (1991) has outlined ways of connecting training and education in counselling, psychotherapy and counselling psychology that connects rather than diversifies them. He suggests a three-stage model depicting pathways in which counselling is (1) integrated in an already existing profession, such as nursing or social work, (2) seen as the primary work of the practitioner, (3) a specialisation in a given area or field, like employee counselling, student counselling, working with eating disorders, marital counselling (psychotherapy training and practice would enter here). Further theory, practice and research that connects counselling and psychotherapy with psychology (or indeed another profession – counselling could be connected to sociology or education or politics) would add postgraduate qualifications to the above, leading to Advanced Diplomas, MA or MSc degrees. Carroll (1991) has also pointed out the problems emerging if the three main organisations to whom counsellors, psychotherapists, and counselling psychologists are affiliated (the BAC, UKCP and BPS) become too isolated and ally themselves to rigid training that refuses to recognise other expertise.

DIFFERENT APPROACHES

For lay persons, as well as helping professionals, it is not exactly easy to find one's way (in addition to disciplinary confusion) around the theories

and psychotherapy prevalent at this time of the late twentieth century. In the professional literature, some 250 different schools or approaches to counselling and psychotherapy have been identified (Corsini 1986); Holmes and Lindley (1989) refer to the existence of over 300 types of psychotherapy. In addition to the difficulties attendant on differentiating professional boundaries, this task can be bedevilled by the incredible range of approaches, theories and schools which are all part of the vast ocean of work conducted by the different professionals in these fields. Karasu (1986) has talked of polling 450 models of counselling/psychotherapy nationwide in the United States alone.

It can be both difficult to identify where particular approaches come from historically, or where they share characteristics or belong *vis-à-vis* other approaches in terms of family resemblances. Dryden's book *Individual Therapy in Britain* (1984) can be extremely useful to help understand the differences between the approaches. Any attempt to map out psychotherapy is fraught with ambiguity and argument, because deep psychological as well as social, ideological and economic factors influence this profession as much as any other. However, many people have found it helpful to have some kind of overall location diagram of major thinkers in psychotherapy, at least to give them some initial starting points (see Table 1.1 below). It is thus not suggested that this table is the only way to do it, or that it does any more than provide the starting point for several debates. However, its usefulness over two decades with psychology students and interested lay people has acted as an encouragement to make it more available. Inevitably, where space and time is restricted, some important names have been omitted. It is hoped that the general notion is clear enough for readers to continue to fill in from their own reading, their inquiries and their own experience.

A brief overview follows of the underlying traditions of counselling and psychotherapy, with a look to the future and the goals of integrative psychotherapy as one of the ways forward.

THE THREE MAJOR TRADITIONS IN TWENTIETH-CENTURY PSYCHOTHERAPY

Three major streams of psychotherapy all originated around the turn of the twentieth century. Freud's (1915/1973) theory of psychoanalysis came to represent one major stream of psychological thinking and psychotherapy. His first major work, *The Interpretation of Dreams*, was published in 1900. Freudian and Kleinian psychoanalytic thinking tended to view human beings as biologically determined, and motivated primarily by sexual and aggressive drives. For Freud, the purpose of psychoanalysis was exploration and understanding or analysis, not necessarily change (1915/1973).

The second major stream derives its theoretical lineage from Pavlov (1927), the Russian psychophysiologist who studied conditioned reflexes and other learning behaviours. Theoreticians following in this tradition are usually referred to as learning theorists, behaviour modification specialists, or latterly, cognitive-behaviour therapists.

In 1968 Abraham Maslow coined the term 'third-force psychology' (1968: iii) to distinguish the third grouping shown below. This tradition did *not* originate from Freud or from Pavlovian ideas. The intellectual and ideological grandfather of this humanistic/existential tradition is Jacob Moreno. Moreno was arguably the first psychiatrist to put 'the patient' in a centrally responsible role in his own life drama. He worked with people to empower them to do their own healing. Moreno was applying group psychotherapy with children based on humanistic existential principles, and writing about it by 1908 (Greenberg 1975: 201).

Professionals and lay people familiar with the inter- and intra-disciplinary squabbles of different traditions will be able to use their own knowledge to augment or modify this presentation in Table 1.1 considerably for themselves. Such attempts at distinguishing between different kinds of service provision can provide basic guidelines for members of the public and trainees, so that needs and resources can be more accurately aligned. The task of providing the best and most cost-effective help for individuals in emotional trouble is complex in itself, and ignorance of the field can intensify the complexity for people already in trouble. For someone who may already be confused and simply in need of emotional help, it may not be easy to find that appropriate help (that holds the least long-term detrimental effects, and the most benefit in terms of improved psychological health). The person may need emergency help and may not have the leisure and rationality to sift through the huge variety of approaches available. Secondly, the ability to know where helping modalities overlap and where they differ can be a tremendous help to professionals themselves. It can establish boundaries, acknowledge strengths and limitations and afford a working relationship between them that fosters mutual respect rather than distrust.

There are some psychotherapists who are quite hard to place in Table 1.1 because they cross over in terms of values or according to their interpreters, or because they have become fundamentally integrated with others. For example, Reich (1945) was primarily from a psychoanalytic lineage, but his influence today is most clearly manifested in the humanistic/existential grouping through the presence of the bio-energetic therapy of Lowen (1969). Further examples are Alice Miller (1979/83), originally a psychoanalyst who sounds very humanistic, and Geoffrey Kelly (1955), who developed a constructivist view. Whereas Masterson (1976) is clearly in the first group, despite his early protestations, Kohut's (1977) actual

Table 1.1 Map of major traditions of psychotherapy

School of therapy	*Psychoanalytic*	*Behavioural*	*Humanistic/ existential*
Founder	Freud	Pavlov	Moreno
Date when active	1893	1902	1908
Comments about philosophy, orientation and practice	Bio-psychological determinism. Analysand lying on couch. Psychotherapist is abstinent/opaque, makes interpretations from position of greater understanding. Centrality of unconscious process and transference relationship.	Behaviours seen as a result of learning and conditioning. Emphasis on experimental research and measurable variables. Stimulus/response chains. Cognitive processes. Working alliance essential.	Centrality of responsibility. Non-interpretative concern with here-and-now. Psychotherapist as person, plus transference in some approaches. Occasionally includes transpersonal. Dialogue and relationship. Real relationship emphasised.
Application	Used particularly for neurotic illness, usually modified approach for other disorders. Select client group.	Used particularly for phobias and obsessive behaviours, also depression. Wide client group.	Used for psychoses, personality disorders and neuroses, but also for growth and development. Self-motivated client group.
Aetiology	Sexual and aggressive drives. Early childhood experience.	Conditioned reflexes. Biology. Contingencies of reinforcement.	Biological, social and creative needs from child to adult.
Techniques	Analysis, free association, dream interpretation, parapraxes, etc. Resistance and transference. Interpretation. Catharsis.	Learning and conditioning. Flooding. Modelling. Desensitisation. Thought-stopping. Role rehearsal. Creation of reinforcement schedules. Other cognitive/behavioural techniques (Hawton *et al.* 1989).	Meaning and change. Feelings expressed. Wide and diverse. Active. Interventionist. Invitation to take responsibility. Creative.
Goal	Resignation to the depressive position (Hinshelwood, 1989: 153). Insight.	Adjustment or elimination.	Self-realisation. Self-responsibility.

Table 1.1 Continued

School of therapy	*Psychoanalytic*	*Behavioural*	*Humanistic/ existential*
Other workers	Bion (1962/84) Bowlby (1952) Anna Freud (1968) Fairbairn (1952) Federn (1977) Jung (1953) Klein (1949) Lacan (Benvenuto 1986) Malan (1979) Samuels (1985; 1989) Symington (1986) Winnicott (1958)	Beck *et al.* (1990) Dryden (1984) Ellis (1962) Eysenck (1968) Hawton *et al.* (1989) Lazarus (1981) Skinner (1953)	Berne (1972/75) Binswanger (1958) Boss (1979) Egan (1975/1982) Frankl (1969) Laing (1960) Maslow (1968) May (1969) Perls *et al.* (1969) Rogers (1986) Rowan (1990) Yalom (1970)
Focus	Why? The past.	What? The present, including the immediate past.	How? The present, including past and future.

position can be ambiguous. Some of Berne's TA followers have remained linked to psychoanalytical developmental theory. Some approaches do not easily fit into this map at all. Hypnotherapy is originally Pavlovian, and systems theorists may be psychodynamic, cognitive-behavioural, humanistic, existential, or all of these in combination or integration (Beutler and Clarkin 1990).

Jung (1953), particularly when thoroughly infused with Kleinian developmental principles, is clearly within the psychoanalytic tradition; for example, in the work of Fordham (1958). However, when the focus is on the positive role of the unconscious, the interactive humanity of the psychotherapist and the person's self-realisation, his theories and approaches are very much more at home with the humanistic/existentialist group. Samuels (1985), in *Jung and the Post-Jungians*, explores some of the important issues of such a debate, and provides an excellent example of how, within the Jungian tradition, different schools have emerged. Also, the humanistic/existentialist traditions have, more explicitly than the others, emphasised the importance of values, self-chosen meaning and the spiritual dimensions of human life and psychotherapy. This has led to the close liaison with approaches to psychotherapy like psychosynthesis, which emphasise a transpersonal view of the person. I believe this transpersonal relationship (however defined) forms an important dimension in all healing encounters. It has been suggested (Rowan 1990) that these transpersonal approaches may even constitute a fourth force in psychotherapy. The wider use of all three therapeutic approaches by counsellors has also blurred differences.

Of course, individual psychotherapists rarely fit into categories, particularly the more experienced they become. It has been found (Heine 1953) that it was not possible, from client descriptions of psychotherapist activity, to determine to which theoretical school a psychotherapist belongs. What differentiates between therapists appears to be, in fact, the names and labels clients attach to the 'fundamental causes' of their troubles. Ever since Fiedler's studies in the 1950s, it has become more accepted that differences in actual practice between more experienced people are considerably smaller than between beginners of different schools and their more senior colleagues. That is, it appears that which theory guides practice is much less important than experience gained in the field.

Internationally, there is now a discernible trend towards integrative or pluralistic psychotherapy which draws on many traditions and does not adhere to only one 'truth'. In the United States, most psychologists say they are integrative; and it is likely that this trend will become more established in the next few years in the United Kingdom (Dryden 1984). Psychotherapy 'after schoolism' is in view (Clarkson 1995a).

In this book we have brought together experienced psychotherapists from a large variety of approaches, ranging from the purist to the eclectic, from hypnotherapeutic approaches to behavioural, from group analysis to cultural perspectives, from orthodox psychoanalytic to humanistic and existential – with all shades in between – to exemplify the richness and diversity of the field.

THE FUTURE

Whatever the nature of psychotherapy in the future, we believe that certain issues will be crucial to the ongoing debate as to its core concerns. First, the concept of change and what it means. As discussed, there are different kinds of change possible within therapeutic settings: problem-solving, environmental change, adjustment, renegotiation (as in a relationship), developmental change (evolutionary) and personality restructuring (revolutionary change). Certain professional approaches may well be more appropriate than others for certain kinds of change within the person and his/her environment. A second area of great interest is that of relationship within therapeutic settings. Research (Norcross 1986) shows that theoretical differences between 'schools or approaches' is far less important in terms of successful outcome of counselling or psychotherapy, than the quality of the *relationship* between counsellor and client and certain client characteristics, including motivation for change and the willingness to take responsibility for their part in the process. Clarkson (1991, 1995b) and Gelso and Carter (1985) have outlined different relationships appropriate to different therapeutic approaches or client groups (also see Chapters 2 and 8 in this *Handbook*).

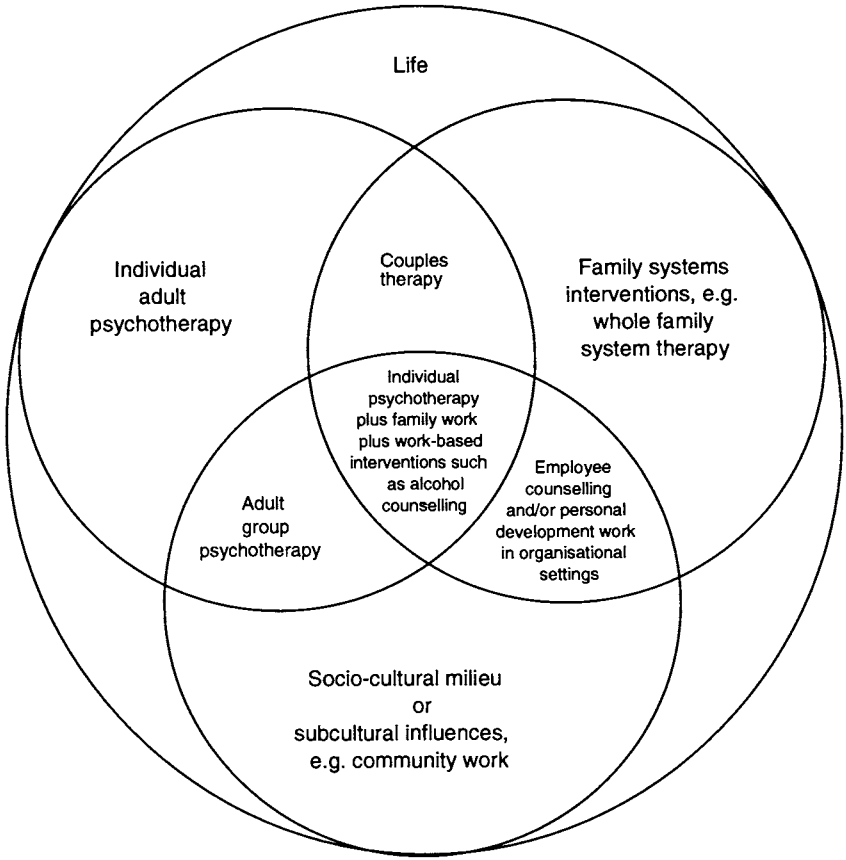

Figure 1.2 The different arenas and modalities of intervention

The third area is that of training. It has now been agreed by all the organisations of UKCP that entry to psychotherapy training must be at postgraduate level and have an academic content roughly equivalent to a master's degree, in addition to supervised clinical practice. It has also been agreed that each psychotherapy training must show that it has adequate arrangements for the trainee to become aware of and manage appropriately their own personal contribution to the kind of psychotherapy being practised. For the psychoanalytically based and humanistic/existential or integrative psychotherapies, these arrangements will continue to be the personal training psychotherapy or psychoanalysis. All require ongoing professional supervision. Further requirements of training courses are evolving gradually and will affect not only the form and content of the courses but are likely to introduce requirements for good educational practice and to establish the universality of external assessment. Moves are

being made to link private psychotherapy trainings with academic units offering psychotherapy diplomas and degrees.

Finally, the question of different arenas and modalities of interventions emerges. Figure 1.2 maps out some of the possibilities. The indication or contra-indication for working with different modalities will be addressed in different chapters as the book progresses. The reader is invited to refer back to this diagram whenever it would prove useful to clarify options, complementary modalities and conceptualisations. Are there clients who could be designated as more appropriately the domain of one approach rather than another? This could be done in terms of the 'change' envisaged (or the degree of disturbance); it could be seen in terms of the training of the helper; it could be viewed from the assessed problem of the client. Or indeed, it might well be a combination of all three. *Systematic Treatment Selection* (Beutler and Clarkin 1990) is a good text with which to explore this.

As all these professions continue to develop as fully articulated disciplines, it is hoped that there would be a rich representation of both specialist and integrative approaches to the field, so that this endeavour of alleviating human distress and increasing human happiness can benefit from the uniqueness of classical exclusivity and purity, as well as from the complexity of pluralism, synthesis or even, occasionally, integration.

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Chapter 2

The psychotherapeutic relationship*

Petrūska Clarkson

In this chapter I want to present a theoretical and conceptual lens through which to view the many and varied contributions which follow in the rest of this book. Not every reader may find themselves in agreement with this, nor is it necessary to accept this perspective in its entirety in order to derive benefit from what follows. However, it is meant to provide a complete contribution in and of itself – a review of five different kinds of psychotherapeutic relationship which may be potentially available for constructive use in psychotherapy. It is also an invitation to engage in, reflect on and view the contributions which follow. Most of the approaches discussed in the previous chapter can be considered in terms of which, or how many, of the five relationships I have identified, are foregrounded or emphasised in the work of the practitioners from that discipline or from that approach. As you read the following chapters, you may be aware of how implicitly or explicitly the relationship is dealt with, and how aspects of it are treated more fully. It is nevertheless my contention that all of these five relationships are available in every psychotherapeutic encounter, available for attention or not, according to the nature of the people involved, the context, the approach and the setting. For example, it may be more difficult to acknowledge transpersonal influences on the psychotherapeutic endeavour in a highly rationalist, experimentally orientated, cognitive-behavioural clinic. Similarly, the ideologies and cultural constraints of some forms of psychoanalysis may impede and inhibit the therapeutic use of, say, the provision of an educationally needed, enacted rehearsal for a job interview, or a longed-for touch on the shoulder when in deep distress. It is my belief that these five modalities of relationship exist in every psychotherapeutic relationship (whether it be with individuals, groups, families or larger systems). Like the keys on a piano, some of them may be played more frequently or more loudly than others, depending on the

* This chapter forms the basis of Petrūska Clarkson's *The Therapeutic Relationship* (London: Whurr).

nature of the music. But they are always potentially there in every therapeutic encounter whether or not the pianist uses them, whether or not the composer acknowledges their existence in the written score.

In this way, I think that the variety and nature of psychotherapeutic relationships is present implicitly or explicitly throughout the psychotherapeutic canon. In working with this material, experienced clinicians tend to recognise that in their own practices some aspects of these relationships are indeed more or less present. Novice psychotherapists have found it very helpful as a matrix from which to learn from many different traditions in psychotherapy and as a framework for integrating what they may still learn; helping them to order, categorise and prioritise the literature while developing precision and purpose in practice.

Relationship or the interconnectedness between two people has been significant in all healing since the time of Hippocrates and Galen. Relationship can be defined as 'the state of being related; a condition or character based upon this; kinship' (Onions 1973: 1786). Relationship is the first condition of being human. It circumscribes two or more individuals and creates a bond in the space between them which is more than the sum of the parts. It is so obvious that it is frequently taken for granted, and so mysterious that many of the world's greatest psychologists, novelists and philosophers have made it a lifetime's preoccupying passion. According to the received wisdom of the late twentieth century, of all the forces of nature it is our familial relationships which often serve to cause the most damage. Statistically you are more likely to be killed by a relation than by a stranger. According to Boss, the great existentialist, all illness and treatment develop out of the patient's disturbed human relationships: 'In focusing on the physician–patient relationship, Freud called attention to the true locus of all therapeutic efforts, whether they were surgical, internal or psychotherapeutic' (1979: 257).

It is the intention of this chapter to make explicit what is often implicit in psychotherapy literature regarding the variety and nature of psychotherapeutic relationships. This chapter reaches for an elucidation of relationship, the *betweenness* of people. It is common knowledge that ordinary human relationships can have therapeutic value. The old structures of religion, accepted moral order and extended family networks used to provide supportive relationships and healing matrices for many people. These appear to have started to crumble in the twentieth century. Indeed, it is possible that psychotherapy as an institutionalized profession became necessary as a consequence of such a decline in the society and quality of healing relationships which were available in previous centuries.

As discussed in Chapter 3 regarding research, one of the most important factors to emerge is the significance of the therapeutic relationship, which is thought to be common to all psychotherapies. 'A constant focus has been on what it is that therapists do which leads to client change' (Barkham and

Elton Wilson, p. 58 in this volume). As discussed in the previous chapter and as emerges from the research, it is very difficult if not impossible to establish with anything more than partisan preferences that any one psychotherapy is more effective than any other: 'All have won and all must have prizes' (Luborsky *et al.* 1975). However, there is a consensus of agreement of the crucial importance of the therapeutic relationship. This has led to a development of integrative psychotherapy on the one hand, and on the other to the broadening and deepening of the understanding of interventions, and to theoretical explorations of many of the unimodal approaches to psychotherapy.

Research, empirical studies and reviews have failed to demonstrate clear advantages differentially attributable to different psychotherapy systems. Research has focused on the identification of the common factor or common ingredients. It seems that success in psychotherapy can best be predicted by the properties of the psychotherapist, the client and their particular relationship. Frank (1979) and Hynan (1981) are two of the many researchers who have found that the client, the psychotherapist and the therapeutic relationship between them are repeatedly more closely related to outcome than whatever technique has been used.

> Most beginning clinicians understand that it is important to live by the basic ground rules of therapy. Confidentiality must be honored, and the boundaries of the therapeutic relationship must be respected, which means remembering every moment that our clients are neither friends nor lovers. Most therapists know these rules, but until one has grasped just how subtle and complex the relationship can be, and how important the therapist becomes to the client, one is likely to seriously underestimate how easy it is to damage the therapy. The slightest breach of confidentiality can be magnified by the client into a major betrayal; a chance encounter with a client outside the consulting room can evolve into a problematic social situation and have serious repercussions. An off-hand remark or thoughtless joke can cause pain or confusion the client may not be able to acknowledge. . . . The second reason for attending to the relationship is that it gives one a major therapeutic advantage. This book will take the position that awareness of the subtleties and changes in the relationship provides the therapist with a powerful tool, perhaps the most powerful therapeutic tool of all. It will try to show why that is true and how that tool might be used in our work with clients.
>
> (Kahn 1991: 2–3)

It was after the publication of my paper that I came across Kahn's book, in which he introduces a perspective on using the relationship as a central factor in all of psychotherapy. Kahn's teacher said, 'The relationship *is* the therapy' (Kahn 1991: 1).

If indeed the therapeutic relationship is one of the most, if not *the* most, important factor in successful psychotherapy, one would expect much of the training in psychotherapy to be training in the intentional use of relationship. Some psychotherapists claim that psychotherapy requires use of only one kind of relationship, or at most two. Some specifically exclude the use of certain kinds of relationship. For example, Goulding and Goulding (1979), transactional analysts, minimise the use of transference, whereas Moiso (1985), also in transactional analysis, sees it as a central focal point of classical Bernian psychotherapy. Gestaltists Polster and Polster (1973) and the existentialist May (1969) focus on the existential nature of the therapeutic relationship. Some psychotherapeutic approaches pay hardly any theoretical attention to the nature of the relationship and they may attempt to be entirely free of content. For example, in some approaches to hypnotherapy or Neuro-Linguistic Programming (NLP), therapeutic changes are claimed to be made by the patient without the practitioner necessarily knowing what these changes may be.

Psychoanalysts, whether most influenced by Freud or Klein or Bion, consider the transference relationship to be the most important, if not the only, defining characteristic of the approach.

THE WORKING ALLIANCE

The working alliance is probably the most essential relationship modality operative in psychotherapy. Without such a working alliance psychotherapy is certainly limited in its goals and restricted in scope. This working alliance is represented by the client's or patient's willingness to engage in the psychotherapeutic relationship even when they at some archaic level may no longer wish to do so (see also Chapter 8 regarding individual adult psychotherapy).

In transactional analysis, the working alliance is conceptualised as a contract or agreement between the adult of the psychotherapist and adult of the client. In psychoanalysis it is 'the relatively non-neurotic, rational, and realistic attitudes of the patient toward the analyst. . . . It is this part of the patient–analyst relationship that enables the patient to identify with the analyst's point of view and to work with the analyst despite the neurotic transference reactions' (Greenson 1967: 29). The attitudes and character traits which further the development of the transference neurosis are basically antithetical to those which further the working alliance (Stone 1961; Greenson 1965, 1967). So it is unlikely that both can become operative at the same moment. Which one is allowed to become figure, or focus, must depend on the nature of the psychotherapeutic task at a particular time with each unique patient. Other modes of therapeutic relationship may also be present but may be more in the background at a particular time.

For many psychotherapists the working alliance is the crucial and necessary relationship for effective therapy (Dryden 1984). It certainly is the necessary co-operation that even the general practitioner requires in order to work effectively with patients, be it simply at the level that the patient takes the medication as prescribed. Anecdotal evidence and research have shown that this working alliance is frequently missing in general practice (Griffith 1990). 'The therapeutic alliance is the powerful joining of forces which energizes and supports the long, difficult, and frequently painful work of life-changing psychotherapy' (Bugental 1987: 49). Bordin (1979) differentiated goals, bonds and tasks – three aspects of the working alliance which seem to be required for any form of therapy to be successful. Several studies emphasise the importance of further common factors:

> Among the common factors most frequently studied have been those identified by the client-centred school as 'necessary and sufficient conditions' for patient personality to change; accurate empathy, positive regard, nonpossessive warmth, and congruence or genuineness. Virtually all schools of psychotherapy accept the notion that these or related therapist relationship variables are important for significant progress in psychotherapy and, in fact, fundamental in the formation of a working alliance.
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> (Lambert 1986: 444–5)

Most forms of psychotherapy use this state of voluntary kinship or relationship more or less consciously and more or less in awareness. The Jungian Samuels states that 'the psychology of the soul turns out to be about people in relationship' (Samuels 1985: 21).

THE TRANSFERENTIAL/COUNTER-TRANSFERENTIAL RELATIONSHIP

This mode of therapeutic relationship is the one most extensively written about, for it is extremely well developed, articulated and effectively used within the theoretically rich psychoanalytic tradition and other approaches (Racker 1982; Heimann, 1950; Cashdan 1988; Langs 1976; Clarkson 1992). It is important to remember that Freud did not intend psychoanalysis to be a cure but rather a search for understanding, and he frowned upon people who wished to 'change' instead of analyse. So the transference relationship is an essential part of the analytic procedure since the analysis consists in inviting the transference and gradually dissolving it by means of interpretation (Greenson 1967).

Laplanche and Pontalis describe transference as follows:

> For psycho-analysis, a process of actualization of unconscious wishes. Transference uses specific objects and operates in the framework of a