Third edition

Classics in Psychotherapy

Storr's The Art of Psychotherapy

Jeremy Holmes

Storr's The Art of Psychotherapy

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Third edition

Storr's The Art of Psychotherapy

Jeremy Holmes

Completely updated, rewritten and revised

CRC Press
Taylor & Francis Group
Boca Raton London New York

CRC Press is an imprint of the
Taylor & Francis Group, an **informa** business

CRC Press
Taylor & Francis Group
6000 Broken Sound Parkway NW, Suite 300
Boca Raton, FL 33487-2742

© 2012 by Taylor & Francis Group, LLC
CRC Press is an imprint of Taylor & Francis Group, an Informa business

No claim to original U.S. Government works

ISBN-13: 9781444144109 (pbk)

This book contains information obtained from authentic and highly regarded sources. While all reasonable efforts have been made to publish reliable data and information, neither the author[s] nor the publisher can accept any legal respon-sibility or liability for any errors or omissions that may be made. The publishers wish to make clear that any views or opinions expressed in this book by individual editors, authors or contributors are personal to them and do not neces-sarily reflect the views/opinions of the publishers. The information or guidance contained in this book is intended for use by medical, scientific or health-care professionals and is provided strictly as a supplement to the medical or other professional's own judgement, their knowledge of the patient's medical history, relevant manufacturer's instructions and the appropriate best practice guidelines. Because of the rapid advances in medical science, any information or advice on dosages, procedures or diagnoses should be independently verified. The reader is strongly urged to consult the relevant national drug formulary and the drug companies' and device or material manufacturers' printed instructions, and their websites, before administering or utilizing any of the drugs, devices or materials mentioned in this book. This book does not indicate whether a particular treatment is appropriate or suitable for a particular individual. Ultimately it is the sole responsibility of the medical professional to make his or her own professional judgements, so as to advise and treat patients appropriately. The authors and publishers have also attempted to trace the copyright holders of all mate-rial reproduced in this publication and apologize to copyright holders if permission to publish in this form has not been obtained. If any copyright material has not been acknowledged please write and let us know so we may rectify in any future reprint.

Except as permitted under U.S. Copyright Law, no part of this book may be reprinted, reproduced, transmitted, or uti-lized in any form by any electronic, mechanical, or other means, now known or hereafter invented, including photocopy-ing, microfilming, and recording, or in any information storage or retrieval system, without written permission from the publishers.

For permission to photocopy or use material electronically from this work, please access www.copyright.com (http://www.copyright.com/) or contact the Copyright Clearance Center, Inc. (CCC), 222 Rosewood Drive, Danvers, MA 01923, 978-750-8400. CCC is a not-for-profit organization that provides licenses and registration for a variety of users. For organizations that have been granted a photocopy license by the CCC, a separate system of payment has been arranged.

Trademark Notice: Product or corporate names may be trademarks or registered trademarks, and are used only for identification and explanation without intent to infringe.

Visit the Taylor & Francis Web site at
http://www.taylorandfrancis.com

and the CRC Press Web site at
http://www.crcpress.com

To the memory of Anthony Storr

Contents

Acknowledgements	vii
Prologue: Anthony Storr and the Art of Psychotherapy	viii
Introduction	
Chapter 1 The setting	1
Chapter 2 The initial interview	4
Chapter 3 Getting going: overcoming initial resistance	11
Chapter 4 Making progress	16
Chapter 5 Interpretation	21
Chapter 6 Dreams, daydreams and creativity	31
Chapter 7 The nature of the therapeutic relationship: boundaried intimacy	39
Chapter 8 Transference and counter-transference	50
Chapter 9 Diagnosis and psychodynamic formulation	59
Chapter 10 Depression	64
Chapter 11 Anxiety	73
Chapter 12 Patterns of personality	81
Chapter 13 The science of psychotherapy	98
Chapter 14 The end of therapy	102
Chapter 15 The life and work of a psychotherapist	111
Epilogue: Beyond therapy	124
References	129
Index	137

Acknowledgements

I am grateful to Anthony Storr's widow, Catherine Peters, and his fellow medical psychotherapist daughter, Sophia Hartland, for helpful corrections, comments and suggestions, all of which have improved both the tone and accuracy of the text. Responsibility for defects and omissions rests of course with the authors!

Prologue

Anthony Storr and the Art of Psychotherapy

The Art of Psychotherapy (AOP) is a classic. First published in 1979, it has been continuously in print ever since. It described in a practical way how to set about offering therapy to psychologically troubled people – a surprisingly rare phenomenon despite a voluminous psychoanalytic literature. It helped demystify a subject which, at worst, is plagued by arcane theorizing and esoteric cultism. Storr brought his many personal and intellectual strengths to this delicate task. His urbane and felicitous style meant that each chapter had the feel of an elegant essay. He comfortably inhabited the wider Western cultural tradition, so that his range of reference extended well beyond the standard psychoanalytic canon. Trained as a Jungian, with a later Freudian analysis, having worked both in private practice and in the National Health Service, and a well-known author in his own right, he was free from the petty demarcations endemic to psychotherapy politics. He brought a truly eclectic and synoptic overview of the aspirations, achievements, realities and limitations of psychotherapy and psychotherapists.

Changed times

But, despite AOP's longevity, times have changed. In the 1970s, Cognitive Behaviour Therapy and Family Therapy were still in their infancy; psychotherapy *was* psychodynamic psychotherapy. No qualifiers were needed; Storr could assume that people would know what he was talking about and generally think of psychoanalysis in positive terms. Today public and professionals alike equate psychotherapy with 'Cognitive Behavioural Therapy' (CBT), while psychoanalytic voices have to fight to make themselves heard.

Storr's book made a number of other assumptions which sound strangely anachronistic to contemporary ears. It was originally directed at psychiatric trainees who wished to learn psychotherapy, and presumed that its audience would be medically qualified males. His advice that therapists should 'not display photographs of their wife and children' in their consulting rooms, despite being sound, is at best amusingly out of date. Today female doctors outnumber males, and psychiatrists form a tiny proportion of psychotherapy practitioners. Most therapists today are women, and come from a diverse range of professions in addition to medicine, including psychology, social work, nursing, teaching, academia, and counselling.

When Storr was writing, the dominant force in psychoanalytic psychotherapy was the British Psychoanalytic Society (BPS) and through it the International Psychoanalytic Association (IPA). There were one or two free spirits like Storr himself – his friend Charles Rycroft was another – but on the whole hegemony rested with the analytic hierarchy. There was no coherent public voice for psychotherapy, which consisted of a number of separate training bodies, infected with the usual rivalries and mutual contempt that bedevil psychoanalytic organizations. After much discussion and at least one schism, there are now umbrella bodies which oversee the training and ethical standards of their member organizations and try to speak with one voice on the public arena. There is a plethora of psychoanalytic psychotherapy trainings, some of which are based in universities, and one that provides an alternative route to membership to the IPA.

Psychotherapy and counselling in their widest sense today have a much more coherent political presence than in the 1970s. The public have put pressure on governments to provide better psychological therapy services, and for mental health services to rely less on drugs and incarceration. In the UK, the Improving Access to Psychological Therapies (IAPT) programme came about through the effective lobbying of CBT therapists, but the still small voice of psychodynamic therapy is also now audible (Lemma *et al* 2008; Lemma, Target and Fonagy 2012).

As psychotherapy moves into the public arena, so its sources of legitimacy have shifted. When Storr was first writing, status, experience and public recognition were sufficient to gain attention. Today, governments and the public demand evidence before they will entertain the claims of authority, however eminent. From the perspective of psychotherapy this is a mixed blessing. Psychoanalysis has always had a strong hierarchical tradition, and has found it hard to accommodate to this democratic shift. Gathering evidence for the effectiveness of psychoanalytic therapies, and showing that it provides added value over that provided by shorter cheaper treatments, is a continuing challenge (see Chapter 13). There are those who feel that the essence of psychoanalytic work cannot be adequately captured by the instrumental values and crude psychometric measures which evidence-based practice requires, and that therapy is as much a secular spiritual journey as it is a biomedical treatment for psychological illnesses. This is a view with which, as a Jungian, Storr had some sympathy, describing the process of individuation which psychotherapy aims to promote as 'a kind of Pilgrim's Progress without a creed, aiming not at heaven, but at integration and wholeness' (Storr 1997).

Nevertheless there are enduring aspects to psychotherapy practice that remain unaltered. While many of Freud's theories have been modified, developed or superseded, his papers on technique (Freud 1911–15) remain as fresh and indispensable to practitioners today as they were a century ago. Similarly, AOP embodies the fruits of a fine intelligence and sensibility combined with deep clinical experience, from which all practitioners can benefit. The skills of psychotherapy can only be acquired by *doing*, under the guidance of an experienced teacher. Therapists learn their trade like any other craft – cookery, beekeeping, playing the piano, skiing, joinery – by supervised practice. Finding an older, wiser, sympathetic mentor is essential; Storr was just such a person and his book was a summation of the knowledge and experience he wished to pass on to the next generation.

Having known Storr, first as a family friend and later colleague, I was therefore delighted and honoured when asked by the publishers and Storr's family to take on the task of updating AOP. This is the result of that work. Readers of the earlier editions will find it changed in many ways. I have used 'reversed sexism', so that therapists are all now female, their patients mostly male; I apologize to my male colleagues if they are offended by this. I have broken up the mellifluous flow of Storr's chapters with subheadings. I have cut and pared ruthlessly. I have added four new chapters, re-titled some, reorganized several, and added new material to all. Despite this, I hope to have remained true to the tone and spirit of the original. I like to think of this new edition as a fresh stem grafted onto exceptionally sound and strong root-stock.

I am an enthusiastic joint-author (Holmes and Lindley1997; Bateman and Holmes 1995; Holmes and Elder 2001; Holmes and Bateman 2002; Gabbard, Beck and Holmes 2005), but have never collaborated posthumously. I hope that AS would approve of what I have done, and not object that I have changed many instances of 'I' to 'we'. On the whole I have not found it hard to decide what to leave, what to rephrase, and what to cut. There remains but one sentence which my better judgement told me to remove, but was so heartfelt that I felt it should stay; I leave it to the diligent reader to pick it out. I am deeply grateful to AS in that he

has saved me the hard graft of writing a book such as this *ab initio*, yet has provided a place where I too could transmit some of the psychotherapy lore I have assimilated over the years.

Anthony Storr (1920–2001)

Anthony Storr was one of that very select band of psychiatrists who have crossed the mysterious barrier between professional eminence to public recognition. For a while he was *the* face of psychiatry on BBC television, and he remains one of the very few psychotherapists who have appeared on the radio programme *Desert Island Discs*, an accolade far more coveted than a knighthood. Most educated people have heard of him, mainly through his best-selling books that throw psychological light on subjects of general interest including aggression (Storr 1968); gurus and their followers (Storr 1997); creativity (Storr 1972); solitude (Storr 1989); sex and sexual deviation (Storr 1968); music (Storr 1992); as well as accessible introductions to the work of Freud (Storr 1989) and Jung (Storr 1973). All illustrate Storr's enviable capacity to communicate complex ideas without oversimplification.

Anthony's parents (his father a distinguished cleric) were cousins; he was the youngest of four children by 10 years, and thus virtually an only child. His early childhood was solitary but not unhappy. Misery set in when, according to the mores of the English upper-middle classes, he was sent away to boarding school. At Winchester, he was lonely and bullied, but acquired life-long passions for both music – he was a gifted pianist and viola player – and reading. A turning point in his life was his friendship with the novelist and scientist C.P. Snow, his tutor at Cambridge. Snow encouraged and valued him, and endorsed Anthony's wish to become a psychiatrist. Snow is best known for his phrase 'the two cultures' – science and the arts – and the deep divide in intellectual life between them (Snow 1973). Storr was comfortably able to reconcile these two aspects, in both his work and writings. Having finally found his vocation and voice – and first wife – Storr did well at medical school and after qualification as a physician, trained in psychiatry at the Maudsley Hospital, then dominated by its intimidating director and guru (see Storr 1997), Sir Aubrey Lewis. Storr (Guardian 2001) commented 'I owed Lewis one thing, at least. Once you had suffered the experience of presenting a case at one of his Monday morning conferences, no other public appearance, whether on radio, TV or the lecture platform, could hold any terrors for you.'

Storr's career can be divided into three main phases. Soon after completing his psychotherapy training, and leaving the Maudsley, he set up in private practice in Harley Street as a Jungian psychoanalyst. Through his personal charisma and writings, especially the best-selling *The Integrity of the Personality* (Storr 1960), he soon became a very successful and fashionable analyst, through whose consulting rooms passed many eminent men and women, academics, artists, writers, musicians and politicians.

Phase two started in 1974 when Storr gave up his private practice, left London, having remarried, and moved to Oxford to take up a post as Consultant Psychotherapist at the Warneford Hospital, under the encouragement of Professor Michael Gelder. He found the academic atmosphere of Oxford extremely congenial, and was friends with leading local figures such as the pianist Alfred Brendel and philosopher Isaiah Berlin. Following retirement from the National Health Service, he remained highly productive in this third phase, continuing to write, and as an active member of Green College where he was a fellow. He was made an honorary fellow of the Royal College of Psychiatrists in 1993, again one of the very few psychotherapists to be so chosen. He was also a fellow of the Royal Society of Literature – again a very rare honour for a psychiatrist and one that meant a great deal to him.

Storr's life illustrates many of the principles he sets out in AOP. The origins of a person's character and conflicts are to be found in childhood. Genetic inheritance sets the scene, physically (Storr attributed his asthma to his parents' consanguinity) and mentally. Developmental pathways, both traumatic (sent to boarding school at an early age; bullying; physical illness) and resilience-enhancing (musical abilities; self-sufficiency) set up life-long dispositions. Solitude can be painful but productive. Creativity helps overcome unhappiness. Sex matters. Resentment and anger (AS's response to bullying; parents who failed to recognize his unhappiness at school) need to be acknowledged and given vent; appropriate assertiveness has a necessary aggressive edge. Finding a sympathetic, older, wiser friend or parent-figure (Snow) can make all the difference to a troubled adolescent. Stress can be strengthening as well as destructive. 'Success' carries narcissistic dangers as well as rewards. Mid-life is a moment for re-evaluation and reviving adolescent aspirations and abilities. Friendship is important to mental health, as is being part of a community. Life post-retirement can be productive and enjoyable.

Parameters

It is now time to move from these preliminaries to the main business of this book – our detailed exposition of how to do one's work as a psychotherapist. A few implicit parameters must be mentioned. As already mentioned, the female personal pronoun is used for therapists. I have expunged the labelling implications of terms like 'the depressive personality' and 'schizophrenics', using instead phrases, admittedly more clumsy, like 'depression-sufferers'. Those seeking psychotherapeutic help are generally, as in AS' terminology, described as 'patients', but occasionally, in more contemporary conventional parlance as 'clients'. The work here described is exclusively about working with adults or late adolescents. For those wishing to explore child psychotherapy Waddell (1998) and Tuber and Catflisch (2011) provide comparable jumping-off points. The nouns psychotherapy, psychoanalysis, psychodynamic psychotherapy, and psychodynamics are used throughout more or less interchangeably, and unashamedly so, since we believe the similarities between them are far greater than any differences. The focus of the book is on the actuality of what goes on in the consulting room, so theory, although a necessary background presence, is kept to a bare minimum. No specific school of psychotherapy is espoused. Our viewpoint is eclectic and integrative, and, wherever possible, evidence-based. Case material is illustrative and fictionalized but has its origins in reality. With that in mind we now invite the reader to embark with us on the fascinating, sometimes perilous, life-enhancing, life-changing journey that is psychoanalytic psychotherapy.

Introduction

Questions, questions

Most people feel pretty anxious when they take on their first psychotherapy or counselling client. How shall I address my patient – formally or informally? Likewise, what shall I call myself? How should I be dressed? How shall I arrange the chairs in the room? Or should I encourage my client to lie on a couch from the start, and if so where should I position my chair? What happens when we 'start' – shall I stay silent or 'take a history'? How much should I guide the interview, or should I just let the conversation unfold? What do I say if the client asks me about my qualifications? What about more personal questions – asking me if I am married, or have ever had a major bereavement, how do I handle that? What happens if they don't turn up – should I telephone or text them? Am I supposed to make 'interpretations'? If so, what exactly *is* an 'interpretation', and how does one 'make' one? What if I am really worried about a client and suspect they may be suicidal? How do I bring the session to an end – what if the client seems to want to go on, or has just got to something interesting, when time is up? Do I take notes during the session, or write the case up afterwards? Help!

There are other important issues depending on the context in which the client is being seen. If it is in private practice – how much should I charge? Should I tell the client how often I expect to be paid – after each session or at regular intervals? If the practitioner has a 'day job' – psychiatry, clinical psychology, or banking (!) – what do I do if my mobile/pager goes off in the middle of a session? At what time of day should I see clients? Is it alright for me to sip my morning coffee when I see them at 7.00 am?

This book is intended to provide some guidance about these sorts of questions, although in the end practitioners will work out for themselves their own way of doing things, and what suits them and their clients best. Our primary focus is always on the *practice* rather than the theory of psychotherapy, although appropriate theoretical texts will be referred to as we go along. Psychotherapy, both for the patient and for the therapist, is an individual, personal matter; any approach which seeks to convey something of what actually goes on during psychotherapy, rather than listing and discussing theories, is bound to be idiosyncratic. Indeed there are those (Bacal 2006) who hold that it is the very essence of psychotherapy to be specific, unique, ungeneralizable. No psychotherapist, and no system or theory, has the key to understanding human beings. But it is possible to assert some general principles about the practice of psychotherapy with which the majority of psychotherapists would agree, however they might argue about points of theory; and this is what we have tried to do in this book.

Definition

We define psychotherapy as follows: the art of *alleviating personal difficulties* through *conversation* in the context of a personal, professional *relationship*. This brings out the three essential components of our work: a suffering individual or patient (as in the Latin, *patiens*, to suffer), the vital importance of speech and language, and a particular kind of relationship, that is at once intimate and yet professional.

The definition of psychotherapy given above may surprise those who think of psychotherapy primarily as a means of curing mental illness. When Freud began his psychoanalytic work in Vienna toward the end of the nineteenth century, abolition of neurotic symptoms was certainly his primary aim, and his patients, though not suffering from physical disease, resembled medical patients closely enough to be labelled 'ill'. Today, psychotherapists are consulted by people whose symptoms are ill defined and many who are not unwell in any conventional, medical sense. A primary motivation in seeking psychotherapeutic help is with what Szasz (1965) has called 'problems in living'; they are seeking self-knowledge, self-acceptance, and better ways of managing their lives. Psychotherapy is as much concerned with understanding people as a whole, and with changing attitudes, as with the abolition of symptoms.

Classifying psychodynamic therapies

This brings us to the question of the many different types and modalities of psychotherapy. We shall be concerned here only with those within the psychoanalytic tradition; that is therapies whose style and theoretical basis originate with Freud and his followers. Students will soon discover that the 'narcissism of minor differences' (Freud 1929) affects the world of psychoanalysis no less than that of politics, and that disputes about what constitutes the 'pure gold' (Freud 1919) of 'real' psychoanalysis, expressive and supportive psychotherapy, high and low intensity analysis etc, are endlessly and sometimes acrimoniously debated. We tend to think that these distinctions, while important, can be over-emphasised, and represent gradations, rather than differences in kind. According to the psychoanalyst Matte-Blanco (1975), the unconscious mind tends toward 'symmetrization' (i.e. abolition of differences), while the conscious mind is drawn to distinctions and asymmetries. Creative living entails both the poetic ability to use metaphor (which is a species of symmetry), and to classify and understand difference (c.f. Dalal 2012).

The psychoanalytic set of cousins within the wider psychotherapy clan are conventionally divided according to frequency of sessions as follows:

Four or five sessions a week: psychoanalysis

Three sessions a week: psychoanalytic psychotherapy

One to two sessions per week: psychodynamic psychotherapy.

It is the last with which we shall be primarily concerned here, and we shall not be addressing other modalities of therapy – CBT, psychodrama etc – or other settings, such as marital and group psychotherapy.

The focus for this book is the kind of therapy that is carried out by psychodynamic counsellors and psychoanalytic psychotherapists, whether in private or externally funded practice, e.g. National Health Service, voluntary sector, or insurance-based mental health provision. Typical frequency of sessions is once or twice a week. We shall not be dealing with psychoanalytic therapies that entail four or five sessions per week. In practice even psychoanalysts see relatively few patients so often (unless they be fellow psychoanalysts in training); and in third-party funded or subsidized services such concentrated therapy is virtually impossible. Although there are some patients who may, for a time, need more frequent sessions, the majority can benefit from being seen only once or twice weekly. If one bases one's position on psychotherapy research findings, there is scant evidence that the

results obtained by 3–5 times weekly analysis are superior to those achieved by less intensive therapy, although studies do suggest that prolonged therapy outperforms brief treatments (Shedler 2010).

Let us turn now to thinking about the setting in which psychotherapy is, or should be, conducted.

1

The Setting

The 'gift' of psychotherapy (Yalom 2002) can be thought of in terms of *space*: a physical space where patient and therapist can meet, protected from intrusion; a 'space in time' that is sacrosanct and set aside exclusively for the patient each week. Above all, patients are offered a space in the therapists' mind, free from extraneous concerns, where they can guarantee that all their attention and focus will be devoted to their clients. Without this psychic space no useful work can be done. Some therapists are oblivious to their surroundings – one devoted NHS analyst claimed that she was prepared to see her patients in a broom cupboard if needs be – but in this first chapter we shall look mainly at the externals and how they can influence therapy, for good or ill.

The room

A number of what commonly might be thought of as inessential details are highly important in psychotherapy. The room that the therapist uses, and the way it is arranged, are significant. In private practice, one is free to arrange and furnish one's consulting room in any way one likes. In hospitals, clinics, social service departments, schools etc where trainees often take their first steps in psychotherapy practice, students are lucky if they have any choice in either the location of the room or in its furnishing and appearance. Nevertheless, there are defined features of how the space in which one is to practice psychotherapy should be arranged; we would urge all psychotherapists to insist that these basic requirements are met by their managers, and to express dissatisfaction when they are not.

Ideally, a room in which psychotherapy is to be undertaken should be furnished as follows. First, there should be a minimum of two comfortable chairs in which both therapist and patients can relax. Psychoanalytic therapy can be described as 'symmetrical but lopsided', a point to which we shall return. The physical manifestation of this is that both client and therapist should be seated on chairs comparable in height and comfort, and indeed ideally of the same design. Some patients will be so tense at first that they will be unable to make proper use of a welcoming chair; but one hopes that as the therapy progresses they will increasingly be able to do so. Being perched on the edge of a hard chair is not conducive to personal revelation, and may put the patient at a disadvantage compared with the therapist, especially if she is more comfortably seated.

Second, there should ideally also be a couch on which the patient can lie down. This should not be an examination couch of the kind which physicians use for physical examinations, but something far more comfortable. A divan bed often proves satisfactory. If suitably covered, this does not look like a bed, to which some patients might object, and which others might welcome with misplaced enthusiasm. It should have at its foot end an extra piece of the same material in which it is covered, which can easily be removed for cleaning. This enables patients to lie down without having to take off their shoes (although most don't mind doing so), which might otherwise dirty the cover. At the other end of the couch should be a number of suitably covered cushions which patients can arrange in any way they find comfortable. The couch should be so placed that the therapist can sit at the