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The Cultural Context of British Psychotherapy

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Psychotherapy and counselling¹ happen most commonly between two individuals, in private. Not only is therapy private when it happens but is also confidential later, so that relatively little of the actual phenomena of therapy, in spite of some consumers' write-ups, disguised case studies, transcribed tape-recordings and conversational analyses, find their way into publications. This book presents the theories of various mainstream therapies structured according to certain historical, conceptual, professional and clinical frameworks, along with case studies. A focus on research, training and supervision is provided in later chapters. In order to provide some wider and integrating balance, this introductory chapter looks at a number of transtheoretical areas to contextualise this most private of activities.

1 THE NATURE OF HUMAN SUFFERING AND PSYCHOLOGICAL NEED

Some of the literature on therapy sustains the impression that it arrived a little over a century ago with Freud and perhaps his immediate predecessors and contemporaries, and that not much of interest or relevance existed or is worth talking about from before that time. But clearly

¹ Given ongoing debates about nomenclature in the talking therapies, and in the spirit of this book, I have used the term 'therapy' interchangeably with psychotherapy, counselling, etc.

human beings have suffered and have had emotional or spiritual needs and aspirations for millennia, even if these have manifested in very different ways. During that time many remedies or solutions have been practised (Ellenberger, 1970). Today's needy or help-seeking client and trained therapist did not appear in a vacuum and we deceive ourselves if we imagine they did.

There are several reasons for including this brief overview. First, while therapeutic theorists are asked to consider their 'image of the person' and human nature, this area of theory is arguably one of the weakest in many models of therapy, probably due to therapists' background lying in psychology rather than philosophy or historically grounded disciplines, and to their naturally prioritising urgent, practical, clinical concerns. Messer (1992) discusses therapists' 'belief structures' and 'visions of reality' and the very language used betrays a certain subjective tenor. Secondly, this weakness is not merely an intellectual inelegance but arguably a potential pitfall for the advance of theory and clinical understanding and for the status of therapy. Thirdly, since the development of evolutionary psychology and psychotherapy, relatively few writers from the ranks of different therapeutic models have kept pace with this trend (exceptions including Burns, 2007; Stevens and Price, 2000). Fourthly, another weakness in most theories of therapy has been in their definitions of the scope of what they can do in relation to what clients need; in other words, a failure to define 'suffering' or deficit or, if this terminology is disliked, then an alternative nomenclature and set of explanations. Fifthly, it is doubtful whether progress can be made towards the integration of therapeutic models without a better philosophical and scientific focus on what it means to be human and to have psychological needs, if indeed any consensus can be achieved in our so-called postmodern era.

There is considerable agreement that we have existed for about 100 000 to 150 000 years in our *homo sapiens sapiens* form. Our ancestors' upright gait probably came about some 4 million years ago, notable increases in brain size took place about 2.5 million years ago, coinciding with significant meat-eating. Some writers have speculated on such distant events and our modern problems with birth difficulties – long, dependent and vulnerable childhoods, over-cognitivation and environmental rapaciousness. Even now, in our contemporary theoretical models of therapy, we are sometimes obliged to make judgements as to whether cognition or emotion is the primary mode of human functioning, the latter being more evident earlier in our evolution and probably having some female bias, the former arguably having connotations of emotion-suppression, control and detachment – some models urge us to think more rationally, others to feel more deeply.

Our original ancestors, probably from Africa, were hunter-gatherers who lived cooperatively in quite small groups. Suggestively, however, use of alcohol is recorded from 7000 years ago and opium 5000 years ago. There is ample evidence of violence and, alongside geographical expansion and technological progress, common anxieties about death. A drastic decline in the nomadic, hunter-gatherer lifestyle occurred about 4000 years ago, coinciding roughly with the advent of the Abrahamic religions. In short, there is a recognisable human story comprising both progressive and destructive, and myth-making and knowledge-seeking elements. We have become increasingly technologised, urbanised and overpopulated (projected to rise towards 8 billion by 2020) and we have not overcome our warring tendencies, although many live in conditions of relative peace and prosperity.

All religions offer accounts of human beings losing deep contact with spiritual identity, suffering as a consequence, and needing guidance or succour. Whether certain individuals hanker pathologically for a bygone age or for lost intrauterine bliss (Freud's 'oceanic feeling') when they present for therapy is a moot point. In roughly the last 200 years, the dominance of industry and capitalism with their attendant effects on working lives is extremely significant. Those forms of unhappy servitude, or what Marx termed 'immiseration', associated with capitalist growth, may or may not be compensated for by the advantages provided by medicine and technology, such as disease reduction and prevention, higher rates of successful births and greater longevity. While some argue that we now live in and need to adjust to a 'post-emotional society', others are alarmed at the loss of emotional intelligence and humanness, qualities that are of course the bread and butter of most forms of therapy.

Many now argue that there is no universal human nature at all, that we cannot speak meaningfully of *a* human nature but only of different theoretical versions, different cultures and individuals. Others argue that we have an all too obvious set of determined characteristics – many of them, like aggression, jealousy, greed and deception, highly negative – which parallel a range of freedoms (Pinker, 2003). Today's debates echo the unresolved nature–nurture debates of past decades. But we can say with confidence that it is in our common nature to be dependent when young, to grow, to couple, to age and die, and along the way most of us struggle and experience non-physical suffering to some extent. If, therefore, we have any human condition shared by all 7 billion of us, it is this – that we must negotiate our way across the lifespan with whatever resources we possess, and most of us are driven to avoid suffering and maximise pleasure, as Freud wrote. Even then, none of us can avoid ageing and physical death and many have far more than their share of loss and sorrow, depending on genetic inheritance, formative experiences, life events, luck, exercise of choices, cultural and idiosyncratic factors. Kleinian and existentialist therapies take some such realities on board more obviously than most other models of therapy. It is also the case that most of us define ourselves and are closely supported by families and communities; and that insufficiencies in care, abuse, shame, loss and rupture in the social domain explain the formation of many of our psychological problems.

Insofar as distinct images of human nature, or pertinent aspects of it, can be identified in the approaches outlined in this book, we might select the following: self-deception, struggle, dualism, trustworthiness, existential becoming, experiencing, OK-ness, cognitive processing, hedonism, storytelling, solution-building, attachment-oriented and evolved. Some approaches have no single clear view of human nature and many regard us as complex biosociopsychological beings. Key questions for exponents of different models of therapy include the following: To what extent is there an agreement on any essence of human nature and its problematic aspects? To what extent does each model either address this and explain how it is incorporated, or dismiss it as irrelevant, and why? Where does each model lie on the spectrum from conceiving human beings as being 'wholly determined' to 'wholly free'? To what extent is each model optimistic or pessimistic in its outlook? To what extent does each model remain open to new information from scientific or other disciplines? Significant differences in answers to these (and one would expect humanistic approaches to be somewhat more

optimistic than psychoanalytic approaches, for example) indicate their implicit philosophies of human nature and potential.

2 ROOTS OF THE PSYCHOLOGICAL THERAPIES

Ellenberger (1970) traces the rise of therapy from the ‘primitive psychotherapy’ of the Guyanan medicine man and the use of drugs, ointments, massage and diet. He also acknowledges therapeutic work with loss of the soul, spirit intrusion, breach of taboo and sorcery across many cultures. Possession and exorcism are phenomena associated with the Christian church as well as many non-Western cultures, Ellenberger making links with the ‘hysterical neurosis’ and attempted cures of late nineteenth century Europe. Ellenberger also lists confession, gratification of frustrated wishes, ceremonial healing, incubation, hypnosis and magical healing, and temple healing and philosophical psychotherapy as forerunners to contemporary scientific psychotherapy. Hence, we can see the seeds of today’s methods in distant history – we can also see, in certain epochs, rivalry between schools of therapy or healing, as in early Greek schools of healing. Albert Ellis’s repeated tribute to the Stoic philosopher Epictetus (55–135 CE) demonstrates a clear link across almost 2000 years between original Stoicism and the modern, psychological, clinical therapy of rational emotive behaviour therapy and cognitive-behavioural therapy (CBT) generally. (See also Nussbaum, 2009.) Many similar ideas are found in the teachings of the Buddha more than 500 years before Epictetus. Let us recall too that Frank’s (1974) anthropologically informed study of psychotherapy acknowledged such sources as well as contemporary transcultural likenesses, arguing that certain common factors could be found universally. The superiority of Western, talking therapy is easily assumed but this is being questioned by some, such as Moodley and West (2005), and arguments put forward for an integration of psychological with traditional healing methods.

Physical, medical or biological models of therapy have early roots and include herbal remedies, blood-letting, emetics, trepanning, acupuncture, neurosurgery, electroconvulsive therapy (ECT) and psychopharmacology among others. Even homeopathy must be considered a form of physical intervention. In the west, psychiatry developed as the extension of medical analysis and treatment into the domain of severe psychological or emotional problems. Psychiatric abuses and failures – unwarranted incarceration, indiscriminate and damaging use of ECT, drugs used as a ‘chemical cosh’ with highly negative side-effects, and crude, botched lobotomies – created much vociferous opposition from patients and formed part of the drive against the ‘biomedical model’ (Bentall, 2010). Today, psychopharmacological treatment for schizophrenia and bipolar disorder, for example, is partly accepted but also strongly objected to by some groups. While a great deal of therapy has been criticised for targeting the self-indulgent ‘worried well’, psychological therapy has been increasingly appropriated and boosted by those suffering from depression, anxiety and similar conditions wanting to talk in an exploratory, cathartic and social learning manner rather than (or as well as) ingesting medication. There is growing research evidence in support of the use of certain medications alongside psychological therapies and in some cases a demonstrated superiority of talking therapy over medication.

The prefix *psyche* comes from the Greek for breath, soul or life. The *psychological* therapies clearly did not properly begin with Freud in 1896, who regarded himself as a neurologist and his discovery, *psychoanalysis* (the ‘talking cure’), as his own creation. Many regard psychoanalysis as having its conceptual and inspirational origins in religious and romantic aspects of the Judeo-Christian tradition. Many of the founders of contemporary mainstream psychotherapies themselves have Judeo-Christian origins. The term *psychotherapy* appeared in 1853 but did not refer to an applied discipline necessarily drawing from psychology. *Psychology* itself appeared as a technical term in 1748 and even then had overtones associating it with ‘soul’. Psychology has of course had its internal battles over identity and has moved significantly from its early insistence that it should scientifically exclude subjectivity. What we generally mean by ‘psychological therapy’ is an essentially talking-and-listening form of help that does not primarily utilise medical or physical means. While this could broadly include any spiritual or philosophical concepts and techniques (these are, after all, not medical or physical), it tends not to. Since psychology is promoted as a scientific discipline, clinical psychology, and latterly counselling psychology, have been advanced as applied scientific professions, in turn suggesting a superiority over earlier religious and philosophical traditions of helping people with their problems in living.

3 CURRENT SOCIOCULTURAL CONTEXTS OF THERAPY IN BRITAIN

Cushman’s (1995) seminal text on the historical development of psychotherapy within the American context remains highly instructive but no directly comparable British text exists. Cushman’s analysis problematises the rise of the peculiarly Western sense of self and Rose’s (1989) analysis of British trends in the rise of psychology and its influences on our sense of a private self has some resonances (see also Wright (2011) for an Australian-based but widely applicable view). Significantly, in spite of a decades-long tradition of couple counselling and group therapy, individual therapy remains by far the preferred choice. We were told by the authors of one piece of (market) research (BACP/FF, 2004) that 21 per cent of the British population had had some form of counselling or psychotherapy and that up to 82 per cent of people would willingly have therapy if they thought they needed it. Previous estimates of the numbers experiencing therapy had been around 5 per cent at most and there may be reasons to doubt a figure as high as 21 per cent. Nevertheless, since the struggling 1970s, when counsellors and psychotherapists encountered a great deal of public and media resistance, acceptance has continued to grow. The visibility and accessibility of counsellors in many GP practices and Improving Access to Psychological Therapies (IAPT) schemes means that therapy is no longer perceived as an elitist, unaffordable or dubious activity but as potentially available and beneficial to the entire adult population. Availability has been buttressed by the presence of free counselling in many colleges and universities, employee assistance programmes and voluntary organisations such as Relate, Cruse and Mind.

Twentieth-century therapeutic provision was driven by a combination of factors: early psychoanalytic pioneers promoting their ideas via medical training, by the personnel of voluntary

agencies and others exploiting American therapeutic practices and by a general enthusiasm for theories focusing on the inner life of individuals and its improvement. Britain became home to several eminent psychoanalysts, the Tavistock Clinic and Institute of Psychiatry were very influential in the dissemination of therapeutic theory and practices. Attachment theory and object relations therapy, driven by Klein, Winnicott, Bowlby, Fairbairn and others, owe much to the British empirical tradition of infant observation; and key figures like R.D. Laing promulgated original views on the limits of psychiatric treatment and the promise of talking therapy.

The sociologist Halmos is well known for his thesis that counselling and therapy came into their own around the 1950s as formal religion and politics were often perceived as not meeting individual needs: 'at least to some extent, the counsellors have been responsible for a revival of interest in the rehabilitation of the individual, and a loss of interest in the rehabilitation of society' (Halmos, 1978: 7). Perhaps the 1960s, 1970s and early 1980s were characterised by a certain secularism, hedonism and optimism (which paralleled the humanistic psychology movement), and respect for formal politics declined markedly in the 1990s and early 2000s alongside a steady turn against left-leaning politics and towards acquisitiveness. But at the same time the growing impact of feminist freedoms, the rise of multiculturalism and gradual acceptance of homosexuality made for an openly diverse society in which consumer demands and health reforms have combined to favour certain forms of counselling and psychotherapy, as well as witnessing a growth of interest in spirituality and transpersonal therapies.

Can it be said that the contemporary social and psychological problems of the British have a character distinct from those of other nations? In some surveys of self-assessed happiness the UK rates relatively highly. Yet some commentators have assessed Britain as a society populated by somewhat depressed citizens who cannot keep pace with the heavy expectations placed on them and who sense that ever greater acquisition and pleasure-seeking do not result in satisfaction but in compromised mental health. Obesity too has become a marked problem for the British. Layard (2003) cites a figure of about 35 per cent for British happiness across the past 40 years but points out that we deserve to be much happier given our level of affluence compared with eastern European nationals. Marked depression and anxiety as national characteristics paint a gloomy picture and one that inexplicably contradicts the more optimistic happiness survey cited above. Trite though the conclusion is, we must assume that UK citizens are pulled between a kind of stoicism and frank demoralisation. George Cheyne's *The English Malady*, published in 1733, celebrated for its portrayal of depression as a very common characteristic, shows that this is nothing new.

The UK has been a major importer of American therapy models, as of most other American commodities. In turn, Britain has provided inspiration for many other countries in developing their own therapy services and professions, as well as a certain positive energy devoted to professionalised therapy and links with social justice. Psychotherapists and Counsellors for Social Responsibility was formed in 1995 to promote the political dimension of therapy, to challenge oppression and to champion better and fairer provision of therapy. Decades ago Reich sought to integrate psychoanalytic with Marxist concepts. Adler, Horney, Fromm and

others attempted to bring social conditions into the aetiological equation. In the heyday of humanistic therapy, Re-evaluation co-counselling had begun to promote the discharge of social as well as individual distress. Groups like Red Therapy sought to combine radical individual and group therapy with social action. Many Jungians in particular focused their analyses on the intrapsychic causes and threats of war. Some practitioners, largely in the urban USA, have created models of 'social therapy' using community group activities in place of individual therapy to help address problems of racism and addiction among others. In recent decades many therapists have drawn attention to the different psychological needs of ethnic minorities, sexual minorities, disabled people and women, all of which groups traditionally fell outside standard models of the aetiology of psychological distress and need. The movement known as critical psychology stands firmly behind such developments. The journal *Psychotherapy and Politics International*, launched in 2003, also attests to a level of commitment to address these concerns. But while these continue, a certain lack of vigour is apparent, possibly explained by the increasing success of counselling and psychotherapy in mainstream health care and their weakness politically.

Smail (2005) is highly sceptical that therapy or therapists will make any serious inroads on the extent of social distress. World events, pivoting around '9/11', subsequent wars, economic downturns and environmental concerns, undermine any naïve fantasy we may have had that daily life is getting better due to therapeutic insights and treatment. No connection is made between increasing worldwide depression and waiting lists for therapy, for example, and the demoralisation and anxiety generated by environmental degradation, employment insecurity and war. Ritzer (2004) shows the prevalence of social problems worldwide – including population growth, inequalities in wealth distribution, ethnic conflicts, family breakdown, disease, crime and so forth – of which diagnosed mental health problems, while extremely serious, are merely one small part. What has been referred to as the 'upstream' aspect of psychological problems (social, economic and political causes) remains unaddressed by the professional bodies in the therapy field, the focus remaining, naturally but unsatisfactorily, on the downstream aspects (the impact on the well-being or otherwise of the individual). As with the question of human nature, it may be that theoreticians and trainers need to explain far better how their models of therapy might answer valid questions about the social context.

3.1 Epidemiological context

Therapy has responded to, indeed been forged by, urgent and obvious psychological distresses and needs. It has developed like many services in an ad hoc rather than a planned way. The awareness of any need for or creation of an epidemiology of psychological distress has therefore been slow to emerge. Clearly, it would be useful to know the extent of the problem we are dealing with on a national scale, if not to be able to predict future needs. But this is complicated by the breadth and non-specificity of the kinds of problems and concerns brought to counsellors and psychotherapists and by their not uncommon indifference to and suspicion of matters of psychodiagnosis and quantification. While the *Diagnostic and Statistical Manual*

of *Mental Disorders, Fifth Edition* (DSM-V, APA, 2013) may confidently list hundreds of psychological or psychiatric disorders, counsellors and psychotherapists will dispute many or even all these. Sanders (2005), for example, gives a radical account of person-centred opposition to the 'medicalisation of distress'. And many of the concerns brought to therapists do not qualify as disorders by compilers of the DSM. The pain of marriage breakdown, bereavement, work stress, relocation – common issues for counsellors in the voluntary sector and employee assistance programmes, for example – may well be considered 'subclinical' presentations by psychiatric colleagues.

Abernathy and Power (2002) confirm the methodological difficulties in and slow development of the field of the epidemiology of mental distress, the first rigorous UK study appearing only in the mid-1990s. This identified significant degrees of fatigue, sleep problems, irritability, worry, depression, anxiety, obsession and panic, and women as experiencing almost all these to a higher degree than men. Other surveys have identified problematic levels of alcohol abuse and suicide (rising among older men) that have led to the short-term stepping up of specific government health policies to tackle them. Layard (2005) has identified the significance of mental distress both in terms of individual suffering and health economics and the struggle continues to have psychological distress recognised – and its treatment duly funded – on a par with physical illness. Many surveys of the benefits of counselling within companies attempt to quantify distress, its relationship with occupational inefficiency and the likely benefits of therapy in addressing it. Worldwide increases in depression are regularly publicised.

The implications of epidemiological surveys, however crude, seem to have been noted belatedly by those overseeing the profession and training of counsellors and psychotherapists. While training courses have flourished, it has been apparent ('on the ground', contrary to Aldridge and Pollard, 2005) that employment for many therapists – in relation to numbers graduating each year – remains relatively scarce: full-time jobs are few, most employment is part-time and many therapists maintain quite small, part-time private practices alongside other work. Rigorously planned psychotherapy and counselling services (planned, that is, on the basis of estimates of the public's psychological needs and of numbers of clinicians needed to meet these) are to date a rarity, although clinical psychology training and provision are guided by such considerations. Almost certainly, the growth of seriousness with which evidence-based practice is taken will inevitably coincide with the development of better epidemiological estimates; and all this in turn is likely, eventually, to impinge on training numbers and theoretical models. To the best of my knowledge, no analysis of mental health problems by aetiology exists. That is to say, extraordinarily difficult though it is, if we were able even broadly to assign psychological problems to clusters of predisposing factors (e.g. biological propensity, perinatal complications, problematic parent-child interactions, early years and later life negative events, impaired life chances, expectable and unexpected losses, individual coping differences and so on), we could hypothetically design and deliver accurately personalised psychological therapy accordingly. Some such attempts have been made, in some cases attempting to factor in gender, but the likelihood is that much more knowledge and time are required before this becomes a significant clinical reality.

3.2 *The professional and stakeholders' context*

Pilgrim (2002) structured his brief history of British therapy into three phases, with the relevant professional bodies duly making their various appearances throughout this period. His categorisation has psychoanalysis and behaviourism as co-existing and competing between 1920 and 1970, 'third force psychology' (the humanistic approaches), pluralism and eclecticism appearing largely after 1970, and a return of professional authority and postmodern criticism after 1980. Let us set over those periods the births of the British Psychological Society (1907); British Psychoanalytic Society (1901); Medico-Psychological Association (becoming the Royal College of Psychiatrists in 1970); Alcoholics Anonymous (1935); the National Marriage Guidance Council (1938, now Relate); first Standing Conference for the Advancement of Counselling in 1970 (becoming the British Association for Counselling in 1977, to which the term 'Psychotherapy' was added in 2000); the British Association of Behavioural and Cognitive Psychotherapies (BABCP) was founded in 1972; the UK Standing Conference on Psychotherapy in 1989 (becoming the United Kingdom Council for Psychotherapy in 1993); the British Confederation of Psychotherapists, breaking away from the UKCP as the more 'purist' psychoanalytic training institutes (1991) renamed itself the British Psychoanalytic Council (BPC) in 2004.

A few key events should be picked out here. Just as Freud had to engage in a battle with the medical establishment over 'the question of lay analysis', so Rogers had to fight against the psychological establishment to launch and legitimately practise his model, a fight which partly fuelled the growth of 'counselling'. In 1971 a government report concerned about the activities of scientologists (Foster, 1971) spurred action among therapists, resulting in the publication of a call for statutory regulation (Sieghart, 1978). This process has had some dramatic ups and downs. Occasional embarrassing events, such as the comedian Bernard Manning's publicised gaining of BAC membership, the failure of the Alderdice Bill, and opposition from many within the psychotherapy world itself, have both stimulated and dogged the professionalisation of therapy.

This small slice of professional history may show some of the emergence of interest groups, how interests cluster and endure, and how the politics of the 'psy-professions' operate. While some bodies represent quite wide spectrum interests (e.g. BACP and UKCP), others such as the BABCP and BPC focus on well-defined schools of practice. Some of these contain individuals and organisations as members, others represent only training institutes. Some, like the BACP, have very large memberships, while others are relatively small. Of BACP's membership, over 80 per cent are female. Overlapping memberships mean that it is difficult to estimate how many active therapists there are in the UK and no accurate figure is available. One crude estimate from a journalistic source had it that in 1993 there were 30 000 paid therapists, 140 000 volunteer counsellors and 140 000 people using counselling skills in their work. Aldridge and Pollard (2005) allude to 37 500 members of pertinent professional bodies, but other estimates raise a figure of 70 000 therapists (Feltham, 2012).

Statutory regulation of therapy has been on the agenda for many years. At the time of writing (late 2012), plans for regulation by the Health Professions Council of psychotherapy and counselling had been abandoned and new strategies to embrace regulation by the Council for

Healthcare Regulatory Excellence/Professional Standards Authority were being embraced. According to Aldridge and Pollard (2005) practitioner training courses numbering 570 were identified, with a variety of titles among these which the authors say ‘can only cause confusion to the public’ (2005: 7). The title of ‘counsellor’ was being used by 54 per cent of those sampled, with 26 per cent using ‘psychotherapist’ and others designating themselves as ‘therapist’, ‘analyst’, ‘psychoanalyst’ or ‘hypnotherapist’: of these 61.4 per cent work with their clients for up to 20 sessions.

4 DIFFERENTLY CONCEIVED AND NAMED THERAPEUTIC APPROACHES

In Aldridge and Pollard’s (2005) survey self-designated humanistic and integrative practitioners represented 57.34 per cent of those responding, 18.25 per cent analytic, 10.52 per cent cognitive, 2.4 per cent systemic and 2.25 per cent NLP/ hypnotherapeutic. In a more detailed section, although still not precise, it appears that the most commonly self-identified approaches are, in order of popularity with practitioners: integrative, person-centred, psychodynamic, cognitive-behavioural, humanistic and then psychoanalytic and eclectic about equal. Each approach is in a sense a different offer of explanation and help for psychological challenges – each is a product of its time, place and creative personalities and each will have some measure of appeal, success and shelf-life. Some will in time be modified, some will become dominant and some will become obsolete. Interestingly, a large discrepancy appears to exist between practitioner preferences and evidence-based indications, and this data cannot tell us what clients’ preferences are.

Broadly speaking, psychoanalysis was dominant at the turn of the twentieth century and challenged only gradually by the rise of the cognitive-behavioural and humanistic therapies from about the 1970s onwards. But we know that even within Freud’s lifetime it proved impossible to develop a model that attracted consensus, with early fall-outs by Adler and Jung being legendary and many subsequent schisms following these. Historians of psychotherapy will continue to analyse such developments but we can speculate with some confidence that departures from the original Freudian model were driven by sincere differences of viewpoint and aspiration, different professional and cultural backgrounds and markedly different personalities. The development of therapy models has been neither primarily collaborative nor scientifically focused and accountable: it has largely hinged on the energy and inspiration of outstanding male figures and their professional intimates. One count has it that a mere 36 named therapeutic approaches existed in the 1950s, this increasing to 250 by 1980 and over 400 by the end of the twentieth century. Some critical commentators suggest that the creation of so many models reflects the scientific indiscipline of a field in which, it seems, ‘anything goes’; the competitive nature of the society from which most therapy models have arisen, that is, the USA; and the idiosyncrasies, proprietorial nature and fame- and profit-seeking motives of their authors.

Whatever the true picture, we have a scenario of proliferation of therapeutic models that some consider unwieldy, confusing and not credible. One text has referred to this as ‘therapy

wars' (Salzman and Norcross, 1990). On the other hand, the integrative movement has continued to seek common ground and rapprochement between therapies. Yet another perspective has it that many apparently different models are in fact quite similar and merely slight variations on common themes. One simplification is to speak simply of cognitive-behavioural and interpersonal models, for example. Interestingly, while one research thrust commends common relationship factors in all therapy as pivotal, another appears to have underscored CBT, perhaps the least of the relationship-focused therapies, as of superior effectiveness; thus leaving us potentially confused as to the relative merits of the relationship-focused and the technique-focused therapies. Lambert (1992) has argued from evidence that a mere 15 per cent of client improvement is accounted for by techniques specific to designated therapy models. By contrast, 30 per cent is due to common factors (empathy, acceptance, warmth, etc.), 40 per cent to extratherapeutic factors (client's ego strength, helpful events and social support) and 15 per cent to placebo factors. Carr (2012: 322–7) summarises evidence that finds even less potency within model-specific *and* common factors. By their very nature, distinct models of therapy do not convey a picture of this kind.

This book presents the case, as it were, for us to take seriously 15 distinct therapy models and a further five broader developments. Although no mud-slinging competitiveness is in evidence, an implicit difference of views exists on human nature, psychological disturbance, therapeutic techniques and style, change process and so on. Also, each purports to have some sort of original edge. Let us ask first what they have in common, and secondly on what grounds they differ. Most obviously, all these models but one (Kleinian) are mainly male-created (Laura Perls is *sometimes* credited with co-creating gestalt therapy; and many women appear more visibly as second-generation proponents of cognitive, person-centred and other approaches). A majority stem from the initiative of one dominant founder, that is, not from lengthy, painstaking research and scientific committee-style deliberations. All but the original psychoanalytic models were created in the second half of the twentieth century. A majority of the founders have Judeo-Christian origins. All have Euro-American origins, with American predominance. All models agree on the taboo against sexual contact with clients and on confidentiality, and most on traditional professional boundaries. All share the view that their approach requires rigorous training and high levels of skill. Most share the view that their model is capable of addressing a wide array of presenting concerns. Some agree on the mixed (determined and free) nature of being human but vary in their views on how free or genetically 'pre-determined' we are. All tend to see therapy as quite necessary, despite sharing the view that individuals have personal responsibility and efficacy independently of therapists.

When we turn to the differences, however, these are much larger. Some approaches (person-centred therapy and behavioural activation) have psychological roots. Many have psychoanalytic affiliations or origins (gestalt, transactional analysis and cognitive analytic therapies most obviously, after the earliest psychoanalytic models); and even the founders of models as non-psychoanalytic as cognitive therapy and rational emotive behaviour therapy originally have psychoanalytic affiliations. One (existential therapy) has a primarily philosophical affiliation. The newest, solution-focused and narrative therapies, draw from systemic and constructivist

views. Some, such as Freudian, Kleinian and person-centred, are ‘purist’ in what they are composed of (that is, minimal integration from elsewhere) and how they are practised, while others, such as Gestalt, cognitive analytic and rational emotive behaviour therapy, have a greater integrative make-up and capacity. Some, such as cognitive and behaviour therapy, and interpersonal psychotherapy, are readily researched and others far less so. They differ in typical length of treatment (compare long-term psychoanalysis with very brief behaviour therapy or solution-focused therapy, for example). They differ with regard to whether therapy is mandatory in the therapist’s own professional development, Freudian, Kleinian and Jungian training most emphatically demanding this, while the more cognitive and behavioural approaches generally do not. Active or passive (client-led) style of therapy is another defining feature (compare Ellis’s with Rogers’s in this regard, for example), as is temporal focus – past, present or future orientation. Most psychoanalytically oriented approaches inevitably focus strongly on past patterns, for example, while existential, Gestalt and cognitive therapies tend to maintain a strong focus on current life and solution-focused therapy an orientation towards the future. Interestingly, compassion-focused therapy draws from the most distant past (human evolution) and applies this to the present.

Whether goals or symptoms are paramount (see the cognitive and behavioural therapies), as opposed to being regarded as implicit or surface features (as in most psychoanalytic and humanistic therapies), is also a key distinguishing feature. Similarly, the extent of therapeutic ambition differs. While behavioural activation is clearly aligned with problem-assessment and goal-attainment, for example, psychoanalysis is ambivalent about specific aims. Freud aspired to mere ‘common unhappiness’, while Rogers wrote hopefully of the ‘fully functioning person’ and ‘the person of tomorrow’. Inclusion or predominance of certain personality and technical modalities – cognition, behaviour, emotion, dreams, meaning, spirituality, etc. – also helps to define each approach. We might say that each approach is constructed and promoted on the basis of a different clinical epistemology; that is, each approach claims to know best how to understand ailing human beings and how to reduce suffering or maximise personal resourcefulness or happiness. What we cannot say is that the popularity of each model equates with theoretical elegance or clinical effectiveness. The person-centred approach, for example, ranking high with many practitioners, has often been criticised as being theoretically light and has *relatively* little empirical evidence to support claims to reliable positive outcomes.

In spite of decades of effort towards integrative rapprochement, no slowing down of the proliferation of therapeutic approaches is evident. Explicitly constructed integrative models such as cognitive analytic therapy have appeared since the 1970s but have unintentionally added to the sum total of therapies rather than reducing it. Integrative literature and conferences abound but this is not reflected in any obvious movement towards practical convergence. Heart can be taken from the number of practitioners, however, who report practising integratively based on professional experience, clinical wisdom and responses to client needs in busy and diverse practice settings. Observers of the initiatives towards a unified profession have sometimes used the simile of ‘herding cats’ to highlight the difficulty of bringing together practitioners who often have fiercely defended affiliations and negative views about

others. We have no rigorous analysis of who the pragmatic integrationists are and who the partisan, politically entrenched are but the attractions and indeed ongoing uncertainties about statutory regulation versus voluntary registration may well exert some influence on the dynamics of the different approaches to therapy.

5 THERAPY AND ITS CRITICS

Psychotherapy and counselling are not *self-evidently* vitally necessary, scientifically justifiable, universally helpful or palatable. The validity of therapy – and of different therapeutic approaches – must be clarified to its funders and consumers. Therapists tend to enter the field as enthusiastic believers (often originally as successful clients themselves) whose belief is reinforced by investment in their own personal training therapy, immersion in self-funded training and personal economic prospects. Historically, therapy has emerged as a set of practices and specialised vocabularies in which adherents are immersed and which have been offered to a public who knows little about them. Indeed, many ‘insiders’ (therapists) do not have an accurate grasp of theoretical approaches other than their own and those charged with conducting public relations exercises for the professional bodies sometimes struggle to convey in accessible terms what is in fact a highly complex field. When it is said that ‘therapy’ works, this is shorthand for ‘we believe that our (dozens of different) therapies work’. Objective research into what troubles people psychologically, why, and what best helps them, has been slow to arrive on the scene (see Chapter 22).

One of the oldest of critiques, famously championed by Hans Eysenck, is simply that therapy does not work, or has insufficient evidence to claim that it works, any better than a placebo or time itself ‘works’. In fact Eysenck really meant that only behaviour therapy worked reliably and psychoanalysis and its derivatives did not. Much subsequent research has eroded the Eysenckian critique. On empirical grounds, critics have expressed scepticism about the actual existence or validity of cornerstone concepts such as the unconscious, Oedipus complex, inner child, repressed memory, actualising tendency, automatic negative thoughts and so on. The propositions of therapists commonly derive from clinical observation and inspiration rather than rigorous experiments or philosophically robust theorising, and often do not express themselves in ways that can be readily tested and verified scientifically. Unfortunately, since so many divergent (aetiological and therapeutic) concepts exist in this field, significant and credible progress in verification is impeded.

Following his own disillusioning therapy as a trainee and his critique of Freud’s seduction theory, Masson (1990) exposed many examples of neglect, malpractice and outright abuse by therapists that he used as a basis for arguing that (a) therapy itself is riddled with abuses of power and (b) this abuse is intrinsic to any asymmetrical therapeutic practice based on expertise, it is endemic and it cannot be corrected. All Masson could suggest for those suffering from mental health problems was non-specific mutual help. His critique has helped to spawn greater efforts to stress accountability and strengthen complaints procedures but, if anything, the voice of the discontented client is getting louder (Bates, 2006). Meanwhile,

there is obviously little the profession can do to assuage the likes of Masson and even the anti-professionalisation lobby among therapists cannot satisfactorily address the implications of his total condemnation of therapy.

Another major source of critiques lies in the socioeconomic and sociocultural domain. While therapy may indeed help individuals to be somewhat happier or more personally resourceful, it cannot modify the social conditions that foster unhappiness (Smail, 2005). It can be argued that the mitigating effects of therapy act positively in a ripple-like manner from individuals outwards to society; but it can equally be argued that a world of 7 billion individuals, or even a country like Britain of 62 million, facing constant, stress-inducing socioeconomic pressures, will not be significantly improved by individual therapeutic efforts. Even more seriously, the energy expended on micro-remedial individual analysis and change is likely to divert attention from the need for the macro-remedial. In other words, therapy in this analysis is seen as somewhat narcissistic, undermining of social change efforts and, indeed, as ultimately futile. It is interesting that Layard (2003, 2005) portrays conditions in Britain, contra Smail, as favourable to greater happiness, given better support from CBT.

Therapy has also remained until recently quite stubbornly indifferent or even opposed to questions of multicultural spirituality or religion and religious adherents' critique of therapy as self-centred rather than community-focused and God-centred. Add to this the rising costs of training for therapy, most of which (with the exception of clinical psychology training) are met by trainees themselves, which reinforces the middle-class nature of therapy provision, and it is clear that therapy is not usually a naturally active ally against poverty, racism, sexism and other domains of oppression. The charge that therapy remains Eurocentric, if not Anglocentric, is not easily dismissed. Therapists may *talk* about empowering their clients, say critics, but this is naïvety at best. All such trends are summarised in Feltham (2013).

6 EMERGING AND FUTURE TRENDS

Simultaneously encouraging and potentially undermining, the growth of acceptance of psychological counselling and psychotherapy in the British NHS signals a turning point in the development of the field. Increasing job opportunities in this domain went hand in hand with an emphasis on statutory regulation. Growth of demand from the public and for evidence in support of therapy is generally accompanied by a demand for greater evidence of exactly what works best and why (Roth et al., 2006). The UK's National Institute for Health and Clinical Excellence (NICE) requires and facilitates the collection of evidence and its dissemination in the form of best practice guidelines on what is considered safe and effective. This has not become 'dictatorial' – and indeed reassurances are given that it will not compromise practitioners' own creative autonomy – but has become influential. Evidence-based practice (or 'empirically supported therapy' in North America) is an international trend with certain advantages and disadvantages and, however disliked by many therapists, is unlikely to be reversed in the short-term.

In 2005 Lord Richard Layard argued for significantly greater funding for mental health treatment ('now our biggest social problem'), and called specifically for the creation of new mental health centres employing an additional 10 000 therapists. Basing his call both on careful economic estimates and the moral case that psychological suffering be treated as effectively as physical illness, within acceptable waiting times, Layard also detailed a perceived need for a specified kind of training focusing on time-limited CBT as the treatment of choice, based on available research findings. At the time of writing, the CBT-emphasis remains but is slowly yielding to argument and counter-evidence. The principle of 'absence of evidence of effectiveness' has tacitly and incorrectly been taken to mean 'ineffectiveness' (*vis-à-vis* many humanistic and psychodynamic approaches) and anecdotal evidence of cognitive behaviour therapists cherry-picking clients and cases of long-term relapse following CBT have been ignored or played down (House and Loewenthal, 2008).

The early dominance of psychoanalysis and psychoanalytic models has gradually given way to the pluralism of psychological therapies available today. This proliferation is welcomed and celebrated by some as mirroring diversity, individuality and trends in postmodernism (Cooper and McLeod, 2011). Others, both critics and custodians of the profession, regard proliferation as a danger, a sign of lack of order. But there is no abatement in the growth of distinct therapies. Models of brief, integrative, systems and constructivist therapy in particular have been growing, as well as evolution-informed approaches such as compassion-focused therapy. Yet alongside this outward appearance of unchecked and credulity-straining multiplicity, it seems likely that many practitioners have been learning to adapt their internalised training models to the demands of their unique clients in their local settings. This is especially true of primary care counsellors who have adapted to work in multidisciplinary teams with short-term contracts with clients presenting with a range of mild to moderate psychological problems.

Another area of growth in model-building and practice adaptation connects what is broadly termed 'spirituality' (and more commonly transpersonal) with psychological therapy. Interest in clients' spiritual and religious lives and the possibility of drawing from spiritual themes to enhance therapeutic progress goes back to Jung and Assagioli, and transpersonal therapy is well established among humanistic practitioners. A combination of changing demographics (the rise of multiculturalism and increasing longevity), critiques of Western therapy as too technical-rational and individual-centred, and a gradual worldwide spread of therapy is highly likely to make an impact. West (2004) uncovered prejudices against discussing the use of prayer and other spiritual practices in clinical supervision, for example, and Moodley and West (2005) present possibilities of greater integration of Western with 'traditional healing' practices. While it is not surprising that Freudians have inherited Freud's extreme scepticism towards religion and scientifically grounded therapists have emphasised rationality in their work, there is a danger of becoming alienated from the client population served. Indeed Rowan (2005) believes that only those therapies that embrace but go beyond the instrumental and relational towards the transpersonal are doing justice to the whole person. Also, of some surprise in recent years has been the successful experimental integration of meditation techniques into forms of

cognitive behavioural therapy such as mindfulness-based cognitive therapy and dialectical behaviour therapy.

At the more materialist, scientific and technological end, we witness continuing research into – as well as controversy over – psychopharmaceuticals, with doctors heavily subscribing anti-depressants alongside or in lieu of counselling and CBT. The trend towards prescribing medication for young people (e.g. primarily Ritalin for attention deficit and hyperactivity disorder, and anti-depressants for low mood among children) has been sharply criticised. Likewise, increasing research in neuroscience can either bring out in force those in favour of identifying and remedying genetic deficits or those seizing on any evidence of links between kindly early experiences and later optimal brain development and mentally healthy behaviour. The field of epigenetics, demonstrating how, for example, certain genes may be switched on in response to traumatic life events and such responses transmitted to subsequent generations, could still vindicate some therapeutic insights. The growth of email counselling and cybertherapy – either in the form of individualised therapist responses or therapeutic computer packages (e.g. CBT programmes for depression) – is probably driven by both a fascination with technology generally and a preoccupation with costs. But it is growing and becoming refined, however many therapists may object to its apparently depersonalising effects and undermining of traditional relationship values.

We might wonder in what ways if any of the more conservative trends of evidence-based practice coincide with much newer and often countercultural initiatives in the therapy field. For example, significant progress has been made by therapy-promoting health economists like Layard (2005) in the UK and Lazar (2010) in the USA, with confident predictions being made about cost-effectiveness. But those who regard our malaise as having much deeper and more extensive roots propose both evolutionary-informed (Gilbert, 2010) and ecotherapeutic approaches (Totton, 2011). It is in the nature of such developments, however, that it takes years for solid results to percolate through the system.

The UK government has used CBT packages to help the unemployed regain confidence and re-enter the job market but this has been thwarted by widespread negative economics. Swelling interest in the positive psychology movement, in neuroplasticity and flourishing, also fits well here philosophically and clinically. Although subject to democratic and economic vicissitudes, such developments if materialised are welcomed by therapists generally. However, some therapists and commentators on the therapy scene would caution against premature and uncritical hopes for universal ‘happiness on the NHS’ or a cradle-to-grave ‘nanny state’ or ‘therapy state’. It would be a supreme irony if the therapy movement that commenced with Freudian radicalism, reinforced by humanistic counterculturalism, spending several decades in a relative wilderness, finally culminated as a victim of its own success in becoming an unwitting instrument of government-engineered socialisation. Put differently, therapy (particularly humanistic therapy) may be in danger of selling out to the values of the medically-oriented marketplace after many years of opposing it and championing the humanly subjective. Therapy watchers will as ever be observing with great interest to what extent the field concedes thus or continues to assert its own insights, values and pluralistic practices.

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