The Trainee Handbook

1 Setting the scene

Sheelagh Strawbridge

Introduction

If you are reading this book, it is likely that you have either begun training in counselling, psychotherapy or counselling psychology or are thinking about it. You may be a little bewildered by the range of training routes, approaches and labels attached to the work that interests you. Your own choice of training might relate to what is available, accessible and affordable or you might be passionate about training in a particular approach or tradition and be able and willing to invest considerable personal resources in gaining access to training. You may well feel a strong pull towards a particular training route but find yourself disappointed in being unable to access it and you may have concerns about employment opportunities. Whatever your position, your interests, motivations, attitudes, values, degree of commitment and so on these will all affect your approach to your training, what you put into it and what you get out of it.

I think it is important to start here because you are entering a rather strange world. It is even difficult to know how to refer to it as each of the labels raises questions of one kind or another. It is a confusing world with disparate approaches and histories coming together in an arena of conflict around issues of professionalization, regulation and an increasing association with health and medicine. This is not surprising as the process of professionalization, whatever the aspiring profession, involves passionate feelings and strongly conflicting interests. There is a lot at stake and the shape of our still forming or perhaps re-forming profession will affect the lives, livelihoods and status of many people both on the receiving and the practising end of services. Nevertheless, while the world you are entering is confusing it is also exciting and the opportunity to be actively involved in shaping it is greater than in more established professions.

It is, therefore, worth spending some time exploring what it means for our practice or range of practices to claim the status of a profession and for a person to enter that profession. In the current climate in the UK the implications of statutory regulation, entry-level thresholds, National Occupational Standards, Standards of Proficiency, National Institute for Clinical Excellence (NICE) guidelines and changing contexts of employment all have a bearing on these questions. Moreover, what is at issue in the UK has wider relevance as fundamental disagreements

concerning the defining characteristics of practice are brought into focus. Here and in the final chapter I would invite you to begin to explore these questions and suggest some theoretical maps to aid that exploration.

The issues are complex and understanding them presents quite a challenge. Nevertheless, you will encounter them during the course of your training and as you enter professional life, so it is not too early to begin to get some sense of what is involved in this first chapter. You can always return to it as the issues come to life in your own experience and demand further consideration. It will be important for you to remember that both this chapter and the final one offer my own perspective and opinions and contribute to an ongoing debate. There are no definitive answers but debate is a vital element in clarifying thinking. I hope that you will engage in this and consider your personal views, attitudes and values, and their implications for you both as an individual practitioner and as a member of a professional community.

I shall, for convenience, refer to our profession as that of 'psychological therapy' accepting the shorthand as an alternative to a list. This seems reasonable as the alleviation of psychological distress and the development of self-understanding, defined in broadly psychological terms, are widely accepted aims of practice. Nevertheless, even to call it psychological therapy, to distinguish it from more physical therapies, is problematic as, for example, some approaches define themselves as philosophical rather than psychological, while our physical bodies and 'body work' are central in others, and there is also a range of arts psychotherapies.

This begs the question as to whether there is one profession or more than one in the process of this forming or re-forming. There may be more significant differences between theoretical approaches within rather than between professional groupings and Pilgrim (1997: 113) notes that, although psychotherapy can produce a strong subjective identity on the part of individual practitioners, it is unusual in that it fails to denote a coherent professional group or discipline. Indeed, our practices and professional organizations have disparate origins that can be linked to current conflicts. It is also worth remembering that, while the focus of this book is on training in disciplines that would define themselves as psychotherapy, counselling or counselling psychology, psychoanalysis (a grandparent of these diverse and often fractious tribes) sits at a little distance and maintains an ambivalent attitude towards them.

Notwithstanding the influence of psychoanalysis, within the mental health services there is an historical connection between psychotherapy and psychiatry that carries a bias towards a biomedical perspective in this context. Counselling, on the other hand, largely developed separately with connections to human potential and self-help movements as well as voluntary services. These tended to hold critical views of mental health provision. So regardless of similarities in practice and client populations, this suggests one source of tension between top-down profession and bottom-up user-oriented roots that relates to the struggle by counselling to claim an equal status with psychotherapy and, in the context of statutory regulation, equivalent professional entry-level thresholds. Counselling psychology has, for this purpose, been included within psychology, which has already been regulated, not without controversy, under the Health Professions Council (HPC) and has a doctoral-level threshold. It seems likely, at the time of writing, that protected

titles will identify three distinct professional groupings with differential entry-level thresholds. This will have implications for salaries and employment opportunities.

It will not be possible in these short chapters to unpick all of this but I think it will be useful to start by focusing on the question of what it means to claim professional status and on some of the issues peculiar to a profession of 'psychological therapy'.

What is a profession?

The word 'profession' has a range of meanings and uses and we can learn from an exploration of these (see for example Hammersley, 2009). Moreover, there are nuances in its use in distinguishing professional from amateur and voluntary. Professional often implies paid and amateur is sometimes used to denigrate performance, though we also recognize that amateur and voluntary work is often highly professional. So in the course of this discussion I think it will be useful to recognize that, although usages overlap, distinctions can be drawn between 'professionalism', with respect to competence, standards and the quality of work, 'professions', as specific groups, and 'professionalization', in relation to the formal claims to status and processes such as the statutory regulation of such groups. It is often helpful to reflect on the particular sense implied in statements.

For now it will serve to note that the assertion of professional status involves claiming competence in specialized knowledge and skills. In our case the basis of this claim is often, though, as noted above, not always, psychology. Tjeltveit, for example, states, 'When psychotherapists assert that they are professionals, they announce, they profess, they make public testimony that they possess specialized knowledge and technical skills that help people with psychological problems' (1999: 255). Of course, how psychological knowledge, skills and problems are defined and who is qualified to claim psychological expertise are the basis of much controversy. We can see similarities with the historical struggle to define and legitimate what became mainstream medicine and it is worth noting that a range of other practices, often termed 'complementary', also exist and make their own claims to legitimacy.

The nature of professions and their role in society is a significant area of sociological inquiry that we can only touch on here but is worthy of more attention. Macdonald (1995) provides a good introduction and Freidson (2001) makes a useful distinction between 'professions', 'technical occupations' and 'crafts', which has some relevance to the discussion of 'de-professionalization' below. Professional power is also an important focus of inquiry and has been subject to political critiques from varying perspectives, either as an agency of social control or as disabling the capacity of individuals to care for themselves (see, for example, the writings of Michel Foucault and Ivan Illich). Let it suffice here to note that power struggles characterize the process of professionalization and emerging professions, according to trait theories, have always sought to monopolize particular forms of expertise and erect social boundaries around themselves. When established, they restrict and control entry through lengthy training and qualifications (see Abbott and Meerabeau, 1998: 3). Statutory regulation gained by some sections of our

profession and sought by others can, in part, be linked to this process and remains contentious. (Mowbray, 1995, still provides much food for thought; see also debates in professional journals such as *Therapy Today*).

Nevertheless, in recognition of the power that knowledge bestows, it is also characteristic of professions that they make a promise to put self-interest aside and act benevolently towards others. They espouse an ideology of public service and altruism and express a genuine desire to prevent abuses of power. The Hippocratic Oath, traditionally taken by physicians and dating back to the emergence of medicine, is the forerunner of our notions of ethical practice and the ethical frameworks, codes of conduct and disciplinary procedures of our own professional bodies. These are, in part, aspects of self-regulation that aim to establish trust, by ensuring some protection for clients. They can be situated alongside legal and political frameworks and ethical, legal and political issues inevitably interrelate. While self-regulation is often cited as a significant characteristic of professions, it has, of course, been brought into question in the context of statutory regulation and we will consider some of the issues below.

So specialized knowledge and skills, generally defined in psychological terms, and ethical practice are two central pillars supporting the claim of psychological therapy to professional status. It is, therefore, in my view, important to ask questions about the nature of ethics, of psychology and of the relationship between them. I have explored these questions in other contexts and what follows draws upon and develops previous thoughts (Strawbridge, 2003a; 2003b).

Ethics and psychology

In the interest of protecting clients from bad practice our professional bodies commit us to ethical standards and codes of conduct. Ethical issues often relate to aspects of conduct, such as the management of boundaries and the non-exploitation of clients, and to dilemmas arising in situations where values conflict, for example, between self-determination and protection. These are important areas of ethical thinking. However, such issues, relating to the standards and conditions of practice, may be seen as *external* to the therapeutic process, which tends to be understood in psychological rather than ethical terms. So the practice of psychological therapy like, for example, the practice of medicine can be viewed in terms of the application of specialized knowledge and skills. The need for ethical standards is recognized because of the potential for abuse, but most practitioners will focus on the development of their specialist expertise. You may find this reflected in your training, where a stress on skills and theoretical understanding can lead to the neglect of an in-depth study of ethical practice. This was perhaps encouraged by the emphasis, of professional bodies, on codes of conduct written as sets of rules as opposed to general principles that were more likely to stimulate debate.

However, the British Association for Counselling and Psychotherapy (BACP) (2002, revised 2010) now has a fundamentally changed ethical framework, as has the British Psychological Society (BPS) (2006, revised 2009 in response to regulation by the HPC). These new frameworks emphasize values and principles and offer less specific guidance in the form of rules. The intention is to encourage a different

way of thinking about ethics and ethical decision making. Their effect is, in part, to draw attention to the way ethical issues are actually internal to professional practice and are about much more than conduct. In medicine, for example, technical advances will lead to life and death dilemmas such as those relating to judgements about the quality of life and the allocation of scarce resources. Nevertheless, in medicine such ethical judgements can still be seen as separate from the technical aspects of practice in a way that is impossible in our work.

The centrality of ethical thinking *within the process* of psychological therapy is highlighted by a significant change in the BACP framework. The explicit introduction of the ethics of virtue alongside those of duty requires us to cultivate personal qualities such as empathy, sincerity and respect as a matter of *ethical responsibility* as well as in the context of *psychological expertise*, which may be suggested by task-oriented language such as 'establishing a therapeutic alliance or core conditions'. This emphasis on the personal qualities and values of the practitioner brings into focus the interpersonal dimension of therapy, and stresses the importance of the quality of therapeutic relationships. It also draws our attention to the particular ways in which ethics and psychology are inextricably linked within practice.

In order to understand this more clearly we need to take a closer look at the nature of ethics. As well as recognizing ethics as a discipline of academic philosophy, Bohme (2001) draws our attention to its connection with the idea of philosophy as a mode of living or a way of life and with practical wisdom. Both of these connections have to do with what he calls 'the art of dealing with serious questions' and are relevant to our professional work as well as to our everyday lives. While being informed by academic study, ethics in this sense goes beyond it. Practical wisdom he sees as centred on public as distinct from more personal concerns. Here the basic values of communal life are at issue and arguments involve the formation of public opinion, social norms and regulation. So ethical or moral questions will arise when matters become serious for a community and affect how it regards itself and what it becomes. In this aspect it is easy to see the interrelationship of ethics and politics, and we shall return to some of these issues that our developing professional community is vigorously debating.

However, I want to stay for the moment with the therapeutic process itself and the way in which psychological therapy is linked with the idea of philosophy as a way of life, where ethical or moral questions are seen as arising when issues relating to how we live our lives become serious for each of us individually. Bohme argues that the formation of personality, who we are and how we regard ourselves, is bound up with how we decide these questions. They are questions that have to do with 'being-human-well' and this is the province of virtue ethics. It can clearly be argued that, when we work with clients on issues relating to who they are and how they regard themselves, we are engaging in an ethical activity in this sense. However, it can also be argued that psychological theories, explicitly or implicitly, contain normative notions about the nature of persons, their health, well-being and potential and that such matters are properly psychological questions and, indeed, the subject of some disputes between differing theoretical approaches to therapeutic work.

This highlights the shared and sometimes contested ground between ethics and psychology that echoes the historical struggle to separate psychology from

philosophy with a consequent devaluing of philosophical questions. The reassertion by some practitioners (see, for example, Gordon, 1999 and 2009; Lomas, 1999 and 2005) of the importance of philosophical questions in our lives and of the philosophical dimensions of therapy is, at least in part, a response to the negative attitude towards such questions of mainstream academic approaches to 'scientific' psychology. Rooted in the ideas of the eighteenth-century 'Enlightenment', psychology situated itself historically as a 'natural science'. It aimed to establish knowledge that was based on 'objectively observable facts', verifiable against 'sense-experience', and favoured the study of behaviour rather than subjective experience. While ideas about natural science have developed over time and modern psychology has become increasingly complex, there is still an inclination towards a natural science model and a separation of truth from values that can lead to ethical questions being seen as external to the discipline itself, though relevant to the conduct of research and the application of its findings. In contexts of practice this favours a stress on technical expertise with ethics limited, as noted above, to the standards and conditions of practice.

It is, however, possible and, in my view, productive of a richer understanding, to seek a rapprochement between philosophy, including ethics, and psychology. We can see ethical and psychological inquiry as complementary. In fact, I would argue that, for example, deepening our understanding of therapeutic relationships in terms of acceptance, empathy and congruence requires this, as these concepts relate to the psychological attributes and skills of each therapist, to her or his ethical virtues and to the declared values of therapeutic practice. Moreover, whatever theoretical approach we adopt with individuals, couples, families or groups, questions will arise which will have both ethical and psychological aspects. So, for example, in each particular therapeutic relationship with an individual I must ask myself: 'What does it mean to encounter this person in this context?'; 'What is my responsibility to this particular individual in his or her world of relationships?'; 'How will I use my influence and professional power in this specific relationship?'; 'How will aspects of my self and my values colour my perception of and response to this person, and how will they enter our relationship through, for example, disclosing or withholding aspects of my personal experience?'; 'When and how will I offer or withhold insights, interpretations or specific techniques?'.

Similarly, when we consider what our clients bring, while there is no doubt that much of their distress can be couched in psychological terms, it is equally the case that their emotional pain is often also moral pain. For example, difficulties around self-worth, family issues and experiences of guilt and shame, together with problematic coping strategies, such as cutting, drinking and starving, bring considerable distress that can be understood psychologically in the context of a person's history. However, they also relate to how questions of duty, responsibility and a commitment to others can conflict with personal needs, self-interest and the desire for individual fulfilment. The distress may be profoundly influenced by the person's moral outlook and their cultural values. So a therapeutic sensitivity to clients' moral choices about how they live their lives, who they are and how they regard themselves, both as individuals and as members of a community, is as important as psychological understanding.

Psychology as a human science

Espousing such an attitude of complementarity requires a shift away from a natural science model of psychology, which, in any case, has always been contested. Indeed, as psychology, history, sociology, economics and social anthropology emerged as empirical disciplines, claims were made that their subject matter was crucially different from that of the natural sciences and that such 'human sciences' required differing methods of study. The German philosopher Dilthey was one early thinker who linked the notion of human science to a theory of understanding and influenced the development of research into human consciousness, subjective experience, meaning and culture. Consciousness and human agency are emphasized in a human science model and values are inseparable from its assumption that human beings have the capacity for choice and personal responsibility, as opposed to being entirely determined by internal and external causes. This has required an exploration of issues relating to describing and interpreting experience and the development of qualitative research methods. It has resulted in strong phenomenological and interpretative traditions across the human sciences.

These traditions recognize that interpretative and explanatory concepts are actively responded to by those whose experience or behaviour is interpreted or explained. As Hacking argues, even psychiatric classifications with a possible biological basis, such as schizophrenia, are 'interactive', always open to revision because 'people classified in a certain way change in response to being classified' (1999: 123). Moreover, the very range of competing psychological theories and therapeutic approaches underlines the value-laden nature of theoretical concepts relating to such things as the nature of persons, their well-being, potential and pathology.

Such a human science model of psychology is entirely consistent with an emphasis on the ethical dimensions of therapy. Personal qualities, moral choices and human relationships are at the heart of the work. A wealth of evidence demonstrates the therapeutic significance of the personal and intimate nature of the client–practitioner relationship in itself and this seems to be supported by recent neuroscience (see, for example, Cooper, 2008; Cozolino, 2006; Hubble, Duncan and Miller, 1999). Work on the theory and research relating to the therapeutic significance of compassion is also worth exploring (Gilbert, 2005) and I think the ethical notion of 'being-human-well' has some affinity with the psychological notion of 'human potential'.

Postmodernism

As we have noted, the view of psychology as a natural science emerged from the Enlightenment. It has been linked with a range of movements in thought that are now termed 'modern'. In recent years, however, the ideas of knowledge and truth that underpin 'modernity' have been challenged under the banner of 'postmodernism'. Postmodernism questions the certainties of modern thought and stresses that knowledge is always limited within perspectives and inevitably value-laden. In acknowledging the broad spectrum of current psychological theories that have been

found useful in therapeutic work and in adopting a human science approach, we can make a link with postmodernism and become alert to their implicit moral and socio-political values. This stimulates ethical and political critique. Indeed, studies within psychology, which engage in such self-reflective critiques of the discipline (such as Burman, 1994; Fox and Prilleltensky, 1997), emphasize the political role that psychological theories play in constructing and maintaining socio-political structures and power relationships.

More specifically, studies of the discourses of psychopathology and psychotherapy pose a considerable ethical and political challenge to established therapeutic practice (see Fee, 2000; Hook and Eagle, 2002; Parker, 1999; Parker et al., 1995) They show how, whatever the approach (biomedical/psychiatric, cognitive-behavioural, psychoanalytic or humanistic), and irrespective of truth claims, all theories situate clients and their problems within normative discourses that, for example, set standards of mental health, adjustment, development or self-realization. Moreover, if taken as truths, they position the therapist as expert and privilege the language of the model over the everyday language of clients and can, themselves, oppress the people they intend to help. It is worth remembering James Hillman's comment on the power of psychological perspectives:

> Once one has been written into a particular clinical fantasy with its expectations, its typicalities, its character traits, and the rich vocabulary it offers for recognizing oneself, one then begins to recapitulate one's life into the shape of the story. One's past too is retold and finds a new internal coherence, even inevitability, through this abnormal story. (1983: 15)

So where does all this take us? It is possible to see postmodernism as undermining all claims to truth and value. This, I think, is a mistake. I do, however, believe that it offers us a complex picture of reality and counsels a measure of humility in the face of such complexity. It highlights to me the importance of viewing psychological theories as helpful maps or stories, ways of seeing that open up possibilities. These have emerged from struggles with life's challenges and research prompted by the desire to understand something of the human condition. We would be as foolish to disregard them as I would be to walk in the English countryside without the guidance of the Ordnance Survey, even though I am still likely to encounter ploughed up paths, bulls in fields, barbed wire and other obstacles that demand a creative response.

I believe that a human science perspective can embrace the complex vision of postmodernism, emphasizing the interactive and value-laden nature of psychology as well as recognizing its insights. In tune with the attitude of Kelly (1963), it adopts the view that human beings (including psychological therapists and their clients) are natural inquirers. One of the things I remember from my undergraduate studies is a statement, I believe by George Miller, about psychology only being of use if it can be given away. I think for us this implies engaging collaboratively with clients in a spirit of cooperative inquiry and together drawing upon psychological knowledge and understanding, grappling with the serious moral matters life presents and recognizing the social and economic circumstances that limit the possibilities of therapy.

Cooperative inquiry and personal encounter

The notions of collaboration and cooperative inquiry may seem to undermine the claim to professional expertise founded on specialized psychological knowledge and skills. I think this would only be the case if we saw this expertise as manifesting itself in ready-made solutions to clients' difficulties. Such a view can be encouraged by the tendency, discussed below, to see psychological distress in medical terms where the onus of relieving suffering is placed squarely on the therapist. While this view can be seductive, and is encouraged by 'modern' habits of thought and medical contexts of practice, I believe it is, as I have suggested, misconceived. Our clients face social circumstances and moral issues that contribute to their psychological distress and personal encounter, understanding and relationship are central to the therapeutic process. Therapy is more about 'being with' than 'doing to' a person. This, as I have indicated, makes demands on us professionally that go beyond a technical expertise skilfully applied and ethics conceived in terms of conduct.

Cooperative inquiry is, however, compatible with a human science approach to psychological expertise that is informed by postmodern thinking. Adopting this perspective we might better view our specialized understanding in terms that are similar to that of a knowledgeable and experienced guide engaged by a client explorer mounting an expedition into unknown territory. A useful guide does not pretend to know the particular territory, but is familiar with the general landscape and available maps as well as being skilled in expedition planning and techniques for negotiating difficult terrain. He or she is also reflective, clear thinking and creative in facing monsters and other challenges. Moreover, such knowledge and expertise will have been gained partly through studying the explorations of others and, at least as importantly, through personal experience and facing the challenges that help to define their own personal strengths and limitations. This is one reason why the training in psychological therapy stresses the value of experience as a client.

A second reason lies in the importance of encountering the power differential in client–practitioner relationships first-hand. This differential is a feature of all professional relationships, however, the highly personal and intimate nature of therapeutic explorations, and the enormous scope for personal influence involved, make sensitivity to the potential for exploitation crucial in this area of work. Personal experience and increasing self-awareness help to alert us to the more subtle dimensions of power and inadvertent exploitation.

Perhaps above all, the demand for us to engage in personal therapy and other forms of self-reflection lies in the recognition that psychological therapy entails interpersonal relationships with clients who are struggling with serious issues relating to how they live their lives and regard themselves. I like Mair's idea of psychology in an 'intermediary mode' which is 'to do with touching and being touched, personally. It is to do with communications which refresh and bring a person to life, open them up to new possibilities' (1989: 44). This highlights the self as our central resource and the significant demands made upon our self-awareness, ethical sensitivity and personal qualities or 'virtues'. It also draws attention to the reciprocity in therapeutic relationships. As therapists, we too are touched, challenged and

changed in our relationships with clients and must find opportunities to process these experiences.

Much of what I have argued about a human science model, the complementarity between ethics and psychology and the interpersonal nature of psychotherapeutic work, nevertheless, seems at odds with current developments to which there are a number of separate but interrelated strands, significantly: progress towards statutory regulation; an increasing association with medicine; and, in the UK, government supported policies for Improving Access to Psychological Therapies (IAPT) within the mental health services. So an exploration of these is necessary and, while I have some regard for the motives and intentions behind these developments, my own view is quite critical of them and it will be important for you to consider your own position.

Statutory regulation and the increasing association with medicine

I have already drawn attention to the tendency of emerging professions to seek to monopolize expertise and restrict and control entry through training and qualifications. Statutory regulation is sought as a way to restrict the right to practise to those who have gained such qualifications. There is a legitimate rationale for this in relation to the protection of the public from poor practice that can be damaging to their health and well-being. As high standards of practice are promoted, statutory regulation is seen as important because professional bodies can only regulate their own members. Outsiders can make illegitimate claims to expertise and practise without reference to ethical frameworks or disciplinary procedures.

It does, however, undermine professional power by dismantling the self-regulatory function and, while there are many obvious arguments in favour of this, it is a double-edged sword. First of all, it is by no means clear that statutory regulation is actually more effective in protecting the public than self-regulation (see, for example, McGivern et al., 2009 and 'The Maresfield Report', 2009, produced jointly by a number of psychoanalytic organizations). Secondly, and perhaps more fundamentally in relation to the character of our profession, the proposed regulatory body, the HPC, steers towards a medicalized view of practice and the demands of employment in health care settings. This favours a natural rather than a human science model and as stated above my own inclination is towards the latter.

The provision of psychological therapy within the context of medicine reinforces the biomedical perspective dominant within psychiatry. So the language of symptomatology, disease and disorder takes precedence over that of social conditions, interpersonal relations, subjective experience and moral responsibility. Categories of illness and disorder have been constructed and articulated in the *Diagnostic and Statistical Manuals* (DSM) of the American Psychiatric Association and the *International Classification of Diseases* (ICD) of the World Health Organization. They have also been extensively criticized (see, for example, Bentall, 2003 and 2009; Douglas, 2010; Horwitz and Wakefield, 2007; Kutchins and Kirk, 1999). Nonetheless, coupled with a heavy bias towards randomized

controlled trials as the test of effectiveness, they form the basis of the NICE approach to recommending treatments to be made available within the National Health Service.

This has far reaching implications and, as diagnostic categories suggest the existence of objective states that are value free and amenable to specific treatments, clearly favours approaches to practice that will sit most comfortably within a clinical world view. Nevertheless, the *DSM* and *ICD* categories actually fall short of the diagnostic standards normally applied to physical illness, where symptoms can be linked to causes. They largely consist of lists of symptoms, which are de-contextualized and not linked to the circumstances and experiences to which they are a response. Treating symptoms without reference to their causes can be dangerous. For example, diarrhoea may be the result of various bacterial and parasitic infections and the cause will affect the treatment; viral infections do not respond to antibiotics, though they may produce symptoms similar to bacterial infections that do; and it could be fatal to treat a persistent headache with analgesics while neglecting to investigate a possible brain tumour. In genuinely scientific medicine symptoms point to and prompt the investigation of underlying causes. Moreover, a physician's competent interpretation of symptoms rests on an in-depth theoretical understanding of disease processes coupled with substantial clinical experience.

Unfortunately, the *DSM* and *ICD* categories are often used in ways that close down inquiry so, for example, someone meeting the symptom-defined criteria for 'depression', will be seen as having a disorder amenable to a specific treatment. However, depression is something of a catch-all category and the focus on symptoms directs attention towards an individual's internal state and away from an inquiry into interpersonal, social, economic and political contexts to which it may be an understandable response. It is certainly worth asking *why* psychological distress, manifest in issues around eating, alcohol consumption and drug use, as well as in anxiety, depression and suicide, seems to be so widespread in our society and increasing (see, for example, Horwitz and Wakefield, 2007; Wilkinson and Pickett, 2010). The current diagnostic approach discourages this. Interestingly, Leader (2008: 13–17) links the increasing diagnosis of depression to the development and marketing of antidepressant drugs and Appignanesi notes that the use of antidepressants rose by 234 per cent between 1992 and 2002. She remarks, 'There is nothing like a much publicized set of pills to invoke a mirroring illness' (2008: 3). While, the effectiveness of antidepressants is now being questioned (see Kirsch, 2009), the diagnostic category remains enshrined within the NICE guidelines, and the basis for a recommendation of specific psychological treatments.

All of this is the subject of ongoing debate and I hope I have said enough to indicate the fundamental tension between a medical model of practice and one based in a human science perspective. It is certainly not my intention to denigrate medicine or natural science as such, only to question their extension into the field of human relationships. There are, however, further concerns relating to statutory regulation and the medical contexts of practice, which I think can best be understood as part of a wider social process that was originally identified by Max Weber and termed 'rationalization'.

Rationalization and the McDonaldization of practice

I have already noted that the *DSM* and *ICD* diagnostic categories make little or no reference to underlying causes and thus do not compare to those of properly scientific medicine. Separated from psychological theories about underlying processes they do not generate lines of inquiry and they also obscure social values and judgements relating to accepted norms of behaviour. So, for example, homosexuality was included in *DSM 3* and, following protests, removed from subsequent editions and it is difficult to see how the 'unspecified maladaptive reactions' listed under 'adjustment disorders' can be understood without a reference to context. Nevertheless, the categories are taken to identify conditions that are understood, can be treated in specific ways and are amenable to the development of NICE guidelines.

This not only directs attention away from social contexts but also from the interpersonal and interactive nature of our work. Moreover, it can lead to an overemphasis on technical competence, defined in terms of skills and techniques, which fails to recognize the importance of an in-depth understanding of the theoretical maps that guide us, prompt inquiry and underpin a genuinely scientific approach, whether human or natural. In relation to practice, I think that this amounts to a devaluing of professionalism and in effect contributes to a process of de-professionalization that is more advanced in other 'caring' professions, which are experiencing increased 'managerialism' and where direct work with service-users is devolved to less well-trained and poorly paid workers (see, for example, Hugman, 1998; May and Annison, 1998). This, I think, can be seen in our own field in the way that the IAPT policy is being implemented. In my own struggles to understand all this, as noted above, I have found Weber's theory of rationalization helpful and Morrison (2008) also provides a useful introduction (see for example Weber, 1974: 13–31).

Rationalization involves the application of criteria of rational decision making, tied to calculable economic efficiency, to increasing areas of social life and is closely associated with the rise of industrial capitalism. Its effect is to construct a complex system that is geared only to increasing productivity. This, coupled with scientific and technological progress, becomes an end in itself, the rationale of the whole system and, as such, beyond question, as opposed to a means whereby human needs may be satisfied. So, for example, at present it seems possible to conceive of a way out of global financial crisis only in terms of a return to growth.

Ritzer (1993) argues that the process of rationalization continues to intensify. He coined the term 'McDonaldization' to characterize the highly controlled, bureaucratic and dehumanized nature of contemporary, particularly American, social life. The fast-food restaurant, built on principles of efficiency, calculability, predictability and control, where quantity and standardization replace quality and variety as the indicators of value, serves as a metaphor for the general mania for efficiency. Increasing areas of social life are subject to McDonaldization through, for example, shopping malls, packaged holidays, hotel chains and digital television.

Even areas such as religion (Drane, 2000), education and medicine are subject to this process. The stress on grades and league tables in education focus attention on what is quantifiable in the end product, rather than the quality of the experience, and health care is increasingly impersonal and technological.

Ritzer also considers the organization and experience of work. He recognizes that 'deskilling' is characteristic of rationalization and that this can be linked to Braverman's (1974) analysis of the degradation of labour under 'scientific management' (Ritzer, 1998: 59–70). Work is highly routinized, thinking is reduced to a minimum and even social interactions (for example with customers) are scripted (Hochschild, 1983). Higher-level skills (such as planning), creativity, critique and genuine human contact, are effectively excluded so both producers and, in the service industries, consumers are systematically disempowered. De-professionalization is part and parcel of this process.

These ideas do, I think, provide insights into the labour market in which therapists are increasingly employed. More specifically, while much can be said in favour of the intention to increase provision and access, the current IAPT initiative does exemplify how, in our field, complexity can be minimized, process routinized and thinking and human contact reduced, for example, by: the strong emphasis on training in techniques (despite the significance of the therapeutic relationship); attempts to operationalize competences; the demand for quantification in efficacy studies (without due regard to the adequacy of the measures or the quality of the experience); the consequent stress on diagnosis (as opposed to the subjective experience of distress); attempts to package delivery through therapy manuals; and, the use of computers to deliver some such packages. (See Strawbridge, 2002 and Strawbridge and Woolfe, 2010, for a more extended discussion of some of these ideas.)

Conclusion

So you are indeed entering a strange world that is rife with conflict and controversy. I have introduced some important issues that you will inevitably encounter in its exploration, and tried to offer some useful maps of the territory. The concerns that I have raised above all relate to the prioritization of technical competence over the interpersonal dimensions of our work. While technical competence is indeed important, it is only part of what it means to be professional which does, I think, imply autonomy and authenticity, the capacity to make and take responsibility for our own judgements. We will return to this in the final chapter but I have already suggested that, in our field, personal reflectiveness, ethical sensitivity, a depth of psychological knowledge and understanding, a clarity of thought and an openness to inquiry are required, and to these I would add a passionate engagement. In offering you my own views and to these perspective I hope that I have stimulated some thought and perhaps provoked you, and I trust that, as you undertake the hard work of the training that this book is designed to help you with, you will continue to ponder, engage in debate and clarify your own thinking. There are no straightforward resolutions to the issues and, in my view, no neutral ground, but there is excitement and the work can offer enormous rewards.

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