

# CONTENTS

<i>Acknowledgements</i>	xi
<b>Introduction</b>	<b>1</b>
<b>1 Psychotherapy in Healthcare: Setting the Scene</b>	<b>12</b>
Introduction	12
Psychiatric morbidity in the population	14
GPs: the first port of call	15
Distinguishing between psychiatry, psychology, psychotherapy and counselling in healthcare	16
Who provides psychotherapy in healthcare?	19
Integrating psychotherapy into mental health services	21
Summary	24
<b>2 Psychotherapy Integration</b>	<b>25</b>
What is psychotherapy?	25
Is psychotherapy a mental health profession?	28
The 'continuum' and 'stress-vulnerability' models	31
Integrating mind and body	33
Medication	34
Integrating psychotherapy within mental health services	36
Models of integration in psychotherapy	38
Integrative psychotherapy: a humanistic approach	41
Summary	42
<b>3 What Might Help a Person in Distress</b>	<b>43</b>
Psychotherapy and the soul	43
Psychotherapy and change	44
Distress as an opportunity for change and growth	45

The building blocks of experience: how do we become who we are?	47
Role of the infant/caregiver relationship	48
The role of intersubjective relatedness in shaping experience	49
When attachment goes wrong	51
Memory and consciousness	52
The multi-dimensional nature of consciousness	53
Multiple memory systems	54
Layers of emotional life and consciousness	55
Psychic maps for organising unconscious life	57
Life-span development	60
Integrative psychotherapy: a humanistic approach to helping a person in distress	61
Summary	64
<b>4 Therapeutic Relationship: Core Concept</b>	<b>65</b>
Core conditions	66
Definitions of empathy	67
Empathy as emotional connectedness	68
Empathy as a basis for inquiry	69
Unconscious communication: transference, countertransference and co-transference	71
What is transference?	72
What is countertransference?	73
Co-transferences	75
The psychic mechanisms for communicating unconscious processes	75
Reparation, revelation and ripening	76
The mystery of reciprocity	79
Summary	81
<b>5 Who Has Come for Help?</b>	<b>83</b>
Referral to mental health services	83
Psychiatric diagnosis	84
Risk assessment	85
Duration of the therapeutic contract in healthcare	86
Assessment in integrative psychotherapy	87
Listening to the client's story	90
Integrative framework for assessment	92

Identifying key therapeutic metaphors	93
Domains of self-experience	94
Infant/caregiver relationship	95
Gender identity and sexuality	97
Social and cultural world	99
Summary	101
<b>6 Therapeutic Skills</b>	<b>102</b>
Core conditions in the therapeutic relationship	102
Establishing the therapeutic frame	105
Communication skills	107
Self-awareness	109
Sustained empathic inquiry	110
Affective responsiveness	111
Revealing hidden meanings	116
Summary	118
<b>7 Therapeutic Process</b>	<b>120</b>
Content and process	120
Working with the therapeutic relationship	121
Working with co-transferences	126
Identifying the origins of unconscious processes in the therapeutic relationship	128
Promoting a coherent sense of self	130
Increasing range in self-experience	134
Negativity or negative transference	136
Transformation and change	139
Guilt and shame	140
Endings	142
Summary	143
<b>8 Ethical Practice</b>	<b>145</b>
Ethical principles underlying the practice of psychotherapy and counselling	145
How do we attempt to establish that we are competent to practice?	149
What is involved in competence?	150
How do we attempt to establish that what we are doing is best practice?	152
Evidence-based practice	154
RCTs of psychotherapy	155

CONTENTS

Efficacy and effectiveness studies in psychotherapy	157
Practice-based evidence	159
Dissenting arguments	159
How do we attempt to keep ourselves fit to practice?	160
How can we be held accountable for our practice?	162
Summary	166
<i>Bibliography</i>	167
<i>Index</i>	181

# PSYCHOTHERAPY IN HEALTHCARE: SETTING THE SCENE

## Introduction

These are some cases referred by general practitioners (GPs):

- A single parent of twenty-seven has self-harmed by overdosing for the umpteenth time since her teens. She has been seen by the duty psychiatrist, assessed as inappropriate for psychiatric services and sent back. The GP is at her wits' end.
- A football playing 'hard' man is referred because, 'unless he gets some help', his wife is going to leave him. The GP says he has suffered a 'personality change' since a near fatal accident two years ago and has been treating him on and off ever since with medication. He is getting worse not better and thinks he's going mad. He keeps bursting into tears at work and his self-image is shattered. He is taking it out on his wife and threatening violence.
- A mother is referred because she is having 'panic attacks'. Her adopted eleven-year-old son has been truanting and stealing from her purse.
- A second generation immigrant is distraught and falling apart, unshaven and unable to perform at work – he found out that his wife has been having an affair with his next door neighbour. He had been working overtime to earn enough to give her and his daughter 'the top brick off the chimney'. He tried to throw himself under a car.

- A young man in his twenties is referred as suffering from 'anxiety disorder'. He has asked to see the counsellor to help him with his 'confidence'. He was taken into care in his teens but no-one had ever spoken to him about what was happening at home – though his bruises had been noted in his medical records. He had in fact been terrorised by his stepfather, suffering constant beatings about the head and body. He was locked in his room and starved. His nose is permanently damaged and he has trouble getting words out, as if punch drunk.

These are examples of the 75 or more referrals from GPs over a two-year period in a general practice setting. They are not just typical of the cases referred in one practice – any therapist working in general practice could paint a similar picture. The average GP, according to Goldberg and Huxley's research, 'manages' 300 such cases a year (Goldberg and Huxley, 1992). Many GPs will tell you that it is in fact more in the region of 90 per cent of the patients they see whose presenting problem involves emotional and psychological distress (Scott, 1994).

These are not medical problems. They may be placed in diagnostic categories such as 'depression', 'anxiety disorder' or 'post traumatic stress disorder', but research evidence confirms what many GPs know too well – that the medical solutions available in the form of psychotropic medication are mostly ineffective and in any case do not address and resolve the underlying issues (Scott, 1994).

Nor are these people 'the worried well' for whom tea and a sympathetic ear could be said to be an adequate response. Their distress is debilitating and its consequences far reaching, not only for their own health and well-being but also for their families and future generations of families. There is ample evidence that a skilled and appropriate psychotherapeutic response could go a long way towards alleviating their distress and enabling a greater sense of mastery over their lives.

Roth and Fonagy's comprehensive review of the research evidence for the effectiveness of psychotherapy concludes emphatically that 'there is sufficient evidence to support the growing acceptance and demand for psychotherapeutic interventions' (Roth and Fonagy, 1996). Unfortunately they are still far from being generally available to the kind of people that present at primary care level.

## Psychiatric morbidity in the population

Estimates of mental ill-health range between 10 per cent and 70 per cent of the adult population. These figures depend on where the line is drawn between 'mental distress' which affects daily living, 'mental disorder' as an impairment of functioning which affects self or others, and 'mental illness' which conforms to a recognisable pattern and can be diagnosed as a discrete category as described in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, DSM-4, 1994). Estimates of the prevalence of 'distress' and 'disorder' are still very inaccurate.

More accurate information is available about 'mental illness' which is treated medically and comes under the remit of psychiatric services. A fairly stable figure of under one per cent of the adult population is the calculated prevalence of schizophrenia. The same figure applies for affective psychosis. Six per cent of the population over 65 suffers from dementia and 15 per cent of this group suffers from 'clinical depression' (Goldberg, 1991; NSF for MH, 1999).

It is Goldberg and Huxley who have most fully charted those sufferers from emotional distress who are not appropriate for psychiatric services. They calculate that a third of attenders in general practice suffer from 'non-psychotic anxiety and depression' (Goldberg and Huxley, 1992).

This figure does not include those suffering from distress described as 'psychosocial', nor those whose emotional problems relate to illness such as cancer, heart disease or diabetes, nor the 'psychosomatic' complaints such as eczema, irritable bowel syndrome and asthma where the emotional component is inextricably linked with the illness. If we add these to the equation, we are contemplating large numbers for whom an appropriate psychotherapeutic response could make a significant difference to the quality of their lives.

Mann (in Corney and Jenkins, 1993) in his chapter outlining the need for psychological therapies in general practice concludes that 'the non-psychotic disorders of primary care are a major public health problem because of their clinical severity and their high economic cost'. The National Service Framework for Mental Health says that 'at any one time one adult in six suffers from one or

other form of mental illness. In other words mental illness is as common as asthma' (NSF for MH, 1999: 1).

### GPs: the first port of call

The GP is still the first port of call for sufferers of all kinds of mental health problems. The British government has made GPs responsible for the local commissioning of healthcare and has furthered the establishment of a primary care-led health service. GP-led Primary Care Groups are responsible for the commissioning of mental health services. It is the GP's job to filter mental health problems and refer patients to secondary services, specialist services or the voluntary and private sector.

Unless there is a practice-based therapist, or they can afford private therapy, there is a gap in the provision of services for people with the kinds of problems outlined at the beginning of this chapter. Thanks to the work of such bodies as the Counselling in Primary Care Trust, practice-based therapists are on the increase, although there is still a wide discrepancy in the standards of training and the approaches to practice available (Parry and Richardson, 1996). Most commonly these services are strictly limited to between one and six sessions. The Community Mental Health Teams and psychiatric out-patient and in-patient services are targeted to deal with acute or chronic, psychotic and organic 'major' mental illnesses, and the problems described here may not be considered severe enough for these services (NSF for MH, 1999). In any case a psychiatric response emphasising a medical approach is fraught with the stigma of mental illness and does not address the emotional and psychological components of the problems.

GPs have an average of six minutes consultation time with their patients. Their vocational training does not include therapeutic counselling or psychotherapy – in fact many still do not even have counselling skills training (Royal College of GPs, 1972; Levitt and Wall, 1992). Training for GPs usually includes some input on the recognition of psychiatric illness and the psychological factors involved in physical illness. In a few cases GPs who are interested undertake further training in psychotherapy. But on the whole the majority of GPs are poorly equipped to deal with emotional and psychological distress. There is evidence that they do not always recognise even severe mental illness (Goldberg, 1991).

More recently vocational training courses for GPs have included consultation skills training, much of which is influenced by the person-centred counselling approach. While this may well have a positive impact on the doctor/patient relationship, it does not provide an adequate basis for responding to the kinds of emotional distress discussed here, yet these are the professionals most commonly dealing with them (Gould, 1991).

## Distinguishing between psychiatry, psychology, psychotherapy and counselling in healthcare

More public and informed debate is needed about the nature of mental ill-health and well-being – both how these may be understood and the range of ways of working with them, and in Chapter 2 there is a more detailed exploration of medical and non-medical approaches. Psychiatric, psychological, psychotherapeutic and counselling interventions have developed from different roots. Their historical, philosophical and theoretical foundations have profound influences on the approaches they take to understanding human nature. Each provides a useful but different perspective on the nature of human distress and it is important to be clear about the distinctions between them. They also have many things in common and their knowledge bases have influenced each other, so that there are many overlapping strands. This has created a good deal of confusion amongst health professionals as well as the public, about what the different disciplines have to offer (Scott, 1995a; Parry and Richardson, 1996).

*Psychiatry* has traditionally looked to the science of medicine and found the roots of human distress in organic problems such as chemical imbalances in the brain or physical lesions. The result has been the categorisation of distress into various disorders that can be diagnosed and treated following the disease model. The solutions to emotional distress that have been psychiatry's contribution have mainly been pharmacological or surgical. Electroconvulsive therapy (ECT) for example is on the increase again within the NHS in Britain (Kendell, 1996).

Psychiatrists are not generally trained to offer non-medical psychotherapeutic interventions. In Britain it is only recently that a basic exposure to some core psychotherapeutic approaches has

become mandatory for membership of the Royal College of Psychiatrists (RCP), and according to Parry's review of NHS services for the Department of Health, only 90 of a total of 4550 psychiatrists had completed a specialised training in psychotherapy, qualifying them for the post of consultant psychiatrist specialising in psychotherapy in the NHS (Parry and Richardson, 1996).

Psychology is an academic discipline and practitioners are required to be eligible for graduate membership of the British Psychological Society (BPS). Psychological interventions are distinguished from other approaches by their emphasis on experimental research. Clinical and experiential considerations have received less attention. Psychology has tended to focus on understandings of how humans grow and develop in normal circumstances. Distress is understood as a deviation from what is considered to be the norm and behaviourism emerged as a theoretical force in the 1940s as a means of treating this distress. Theories of learning derived from animal experimentation were applied to humans, bringing experimental methods to human psychological processes. The solutions that have been psychology's contribution have mainly focussed on the alleviation of the behavioural symptoms of distress.

Early scientific interest in psychological treatment was fostered by the British Psychological Society founded in 1912. Early work by Skinner and Wolpe in the 1950s and 1960s was influential at the Maudsley Hospital and the Institute of Psychiatry in London, and by the 1960s, behavioural treatments were available in many mental health services throughout Britain. The cognitive revolution in academic psychology in the 1970s led to a new emphasis on cognitive processes in therapy, and many behavioural therapists incorporated cognitive principles into their work. Cognitive behavioural therapy (CBT) is by far the most widely available psychological intervention within the NHS. It is the approach most often offered by clinical psychologists.

The BPS has divisions of counselling and clinical psychology, and bestows chartered status on clinical or counselling psychologists who have successfully completed the Society's training and qualification procedures. There is currently no division of psychological psychotherapy, only a special interest group (BPS, 2002).

*Psychotherapy* has developed in the context of clinical practice. Theories have evolved as a result of research based mainly on

case studies of adults, and to a lesser extent children, in distress and undergoing treatment. Their focus has been on the subjective experience of distress and the underlying psychological mechanisms involved. Psychoanalysis and the humanistic/existential tradition are the two major theoretical streams within psychotherapy that have evolved in this way.

In Britain the earliest psychotherapeutic treatments were largely psychoanalytic and before the War available to only a few and mainly in London. The Institute of Psycho-Analysis was founded in 1919 and the Tavistock Clinic in 1920. With the birth of the NHS in 1946, psychoanalysis was made available to NHS patients through the Tavistock Clinic. In the 1940s and early 1950s a 'third force' in psychotherapeutic theorising was emerging mainly in the United States – humanistic psychology. The humanistic paradigm developed partly in reaction to perceived limits of the other two dominant forces at that time, behaviourism and psychoanalysis, to 'adequately account for the key questions of human experience' (McLeod, 1993: 133). The European philosophical traditions of phenomenology and existentialism had a profound influence on humanistic thinking. In the 1970s a number of psychotherapies were developed within what became known as the 'human potential movement' with a distinct domain of theory, research and practice all drawing on a core set of philosophical and psychological assumptions.

*Counselling* is in many ways even more confusing. There are some in the profession that do not consider that there is any difference between counselling and psychotherapy. However, counselling covers many forms of interpersonal transactions that would not be thought of as therapeutic, such as advice, guidance, support and information giving. The term 'therapeutic counselling' has been coined to clarify the situation, but it is not yet commonly used. Many approaches to counselling, in particular those that emphasise working with dimensions of the therapeutic relationship, have more in common with some psychotherapies. Some approaches that call themselves psychotherapy, in particular those that are more structured and time-limited, would be thought of as counselling by others.

The distinction between psychotherapy and counselling that is generally accepted in Britain is based on training standards including the level of entry to training and the level and length

of the training. Psychotherapy is a postgraduate training of a minimum of four years before qualification and registration. Counselling is normally at undergraduate level and involves a minimum of 450 hours (approximately two years) of training before accreditation can be applied for. The training programmes for psychotherapy are mainly validated and regulated by professional bodies such as the UKCP, whereas a counsellor can put together their training from courses that have not been validated and apply for individual accreditation. However many counsellors also have postgraduate qualifications, and an increasing number of counselling training courses are being validated by professional bodies such as United Kingdom Association for Therapeutic Counselling (UKATC), Universities Psychotherapy and Counselling Association (UPCA) and the British Association for Counselling and Psychotherapy (BACP).

### Who provides psychotherapy in healthcare?

Psychotherapy is provided by a wide range of health professionals, including psychiatrists, GPs, psychologists, nurses, social workers, occupational therapists and physiotherapists. What they mean by psychotherapy and the length and kinds of training they have received to practice vary greatly. One of the most striking findings of Parry's review is the degree of confusion surrounding the term 'psychotherapy' and the way it is understood by Trusts and Health Authorities (Parry and Richardson, 1996).

A number of these healthcare professionals have undertaken psychotherapy or counselling training, and in some cases they are formally trained to the standards set by the national umbrella organisations representing the psychotherapies and counselling such as the UKCP or BACP. Far too often, however, they have participated in one or two short courses (Scott, 1995a).

Healthcare professionals may have opportunities within their own professional role to offer therapeutic contact or in some cases a more formal psychotherapeutic contract. However there can be problems associated with dual role-therapeutic relationships. There are contradictions for example in combining the statutory obligations of medical or social work responsibilities with a psychotherapeutic agenda. The training of health professionals in particular is deeply imbued with the medical model, and professionals trained

in this way may have difficulty shifting their own value base. There is often an overwhelming workload with administrative and managerial imperatives which limit the time for psychotherapeutic or counselling contact. Nevertheless good practitioners who are aware of these issues are sometimes able to offer a more useful service.

In order to put some clarity into this situation, Parry defines psychotherapy broadly as referring to 'all systematic psychotherapeutic interventions aiming to ameliorate a mental health problem' (Parry and Richardson, 1996: 13). She identifies three different approaches to intervention that are practised widely in the NHS and provides a framework for clarifying the types of NHS provision which can be subsumed under 'psychological therapies'. She makes it clear, however, that there is no consensus on whether all are appropriately considered to be 'psychotherapy'.

The three categories she identifies are Type A, B and C:

Type A is a psychological treatment as an integral component of mental health care. This describes a wide range of interventions offered alongside other types of care where the primary role of the practitioner is other than psychotherapist or counsellor. Types B and C are complete, stand-alone interventions offered in the form of a series of sessions following an assessment which generates a therapeutic plan.

Type B is eclectic psychotherapy and counselling informed by more than one theoretical framework. Non-directive counselling and psychotherapeutic work that uses a range of techniques to address different facets of a patient's problem is included in this category. Therapeutic counsellors and clinical psychologists are the main providers of this kind of intervention according to Parry's review.

Type C refers to the formal psychotherapies. These are practised within particular models, well-developed bodies of theory and protocols for practice. Integrative psychotherapy is included in this definition. Formal psychotherapies are undertaken by, or under the supervision of, a specialist practitioner formally trained in psychotherapeutic work within a particular school. Some practitioners have trained and are competent in more than one model.

## Integrating psychotherapy into mental health services

There are many psychotherapists who do not believe that it is appropriate to place psychotherapy in the context of public healthcare.

There are many reasons for this. Public sector services are currently led by the medical profession. This has widespread implications for the way that emotional and psychological issues are addressed. They may become subsumed in and shaped by the disease model and the medical agenda. For many psychotherapists psychotherapy is less about alleviating distress and more to do with facilitating growth and self-actualisation. The ethos of treatment and cure that prevails in the health services in their view irrevocably distorts this goal. In Chapter 2, these issues and the consequences for people in distress will be explored in more detail.

However, I believe psychotherapists have a role to play in bringing psychotherapeutic insights into the medical arena and to influence the system. The medical profession itself has been moving towards more and more complex understandings of the holistic bases of health and disease (Scott, 1996). They are beginning to recognise that medication and medical solutions are not the only answers, and that the emotional and spiritual resources of a person have a profound impact on their capacity to heal (Goldberg, 1990). Models that integrate the biological, psychological and social elements involved in disease are being developed all the time. In particular I believe that the predominantly physical approach to psychological perspectives on illness needs to be addressed (Scott, 1996). The evidence from neuroscience and infant studies suggests that there is a much closer interconnection between mind and body than is conventionally considered (Stern, 1985; Schore, 1994, 1997, 2001). In my view the humanistic theories have most radically challenged the mind/body split (Scott, 1995b). A central tenet of these approaches is the integration of the physical, emotional, intellectual and spiritual dimensions of personhood and the self-healing and self-regulating capacity that results from this (Reich, 1945; Rogers, 1951; Rowan, 1976; Boadella, 1987). This is their unique contribution and it offers an important counterbalance to the medicalisation of distress.

Of further concern to some psychotherapists are the implications regarding the therapeutic contract in the public sector. Public healthcare is funded by central government. We pay for it indirectly through our taxes. In some people's opinion this distorts and undermines the responsibility that is intrinsic to the therapeutic relationship and process, particularly in psychodynamic or humanistic/existential method. Clients are dependent on what services and approaches are available and what others in authority think is right for us. Therapists must comply with conditions that are motivated by considerations such as economics that may interfere with what they think is best for the client.

The idea that in the private sector we have more free choice is in my view an illusion. We are always limited by our knowledge, contacts, and financial and other resources in our choices, and we have the same potential to feel or not feel our own authority and exercise our responsibility whatever the setting. For people in distress it is often particularly difficult to exercise responsibility. The nature of distress in itself interferes with our ability to respond. Whatever the setting, therapists need to remain aware of this and take it into account in their practices. Chapter 8 on ethical practice explores these issues in more depth.

Three major reports into the state of psychotherapy services in the NHS have been published by the Department of Health. The Parry report previously referred to looked at current NHS psychotherapy services and strategic policy (Parry and Richardson, 1996), Roth and Fonagy (1996) reviewed psychotherapy outcome research, while the Damon report (1997) incorporates the findings of the first two reports and makes recommendations regarding the commissioning and funding of training in psychotherapies for the NHS.

The Damon report (1997) emphasises the importance of psychotherapy not being understood as referring only to specialist and psychoanalytically based approaches. It recommends the development of services for people with mental illness and distress which are 'person-sensitive' and 'individually oriented in a broader sense which goes beyond equity of access to a particular range of treatments'.

The mental health services in Britain still offer very little response to emotional and psychological problems other than medication, containment and social support services for those

with acute and enduring mental illness. The main findings of Parry's review confirm that the demand for psychotherapy in the broadest sense far exceeds the supply of competent practitioners within the NHS workforce and that availability of psychotherapy services is extremely inequitable both geographically and socio-economically. The picture is one of the haphazard and idiosyncratic local arrangements with no coherent national strategy.

It is clear that a wider range of approaches should be available to respond to the large group of people categorised in psychiatric terms as suffering from 'minor' mental health problems. Looking at the distribution of approaches chosen by the public in primary care, the voluntary and private sectors, a survey conducted by the UKCP (1996) showed that a far greater range of interventions is preferred by clients. Organisations representing service users such as the Mental Health Foundation confirm this picture (Falkner, 2001).

During the last decade in Britain the Department of Health has introduced many policies that are designed to address these problems. The white paper 'The New NHS' was introduced in 1997 and provided a framework to support local NHS organisations as they implement the statutory duty of quality that was placed on them through the 1990 NHS Act. Clinical governance was the centrepiece of these policies and intended to provide the opportunity to develop the fundamental components required to facilitate the delivery of quality care. These were described as a 'no blame, questioning, learning culture' with 'excellent leadership and an ethos where staff are valued and supported as they form partnerships with patients' (Halligan and Donaldson, 2001: 1413). Clinical governance represents the systematic joining up of initiatives and offers a structure for the setting and monitoring of standards. It has been defined as 'a framework through which NHS organisations are accountable for continually improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (Donaldson and Gray, 1998).

Mental health was one of the priority areas in 'Modernising Health and Social Services: National Priorities Guidance for 1999/00–2001/02' and included as one of the four key areas in the white paper 'Our Healthier Nation'. 'The National Service Framework for Mental Health' was introduced in 1999 to drive up quality

and tackle variations and inconsistencies in the present services. An important change in the last decade arising from the growing awareness of the role of emotional and psychological factors in the health of the nation has been the emphasis on incorporating non-medical responses, in particular the 'psychological therapies' in the public sector.

The Parry report concludes that in Britain a psychotherapeutically competent workforce is needed which includes all approaches to helping individuals and addresses 'behaviour, thoughts and feelings through talking, therapeutic relationships and experiences' (Parry and Richardson, 1996). She recommends that a proper framework for psychotherapy should be developed in which assessment and interventions can be decided upon, carried out and evaluated.

## SUMMARY

- In this chapter, issues of mental health and illness have been discussed including the prevalence of emotional and psychological distress and the ways in which these are understood and responded to particularly in healthcare. It argues that a wider range of responses than is currently available is needed and looks at current initiatives in Britain to address the problems in the current service provision.
- The following chapters attempt to explain the real differences and similarities in the various theoretical approaches to understanding human nature in distress. They offer integrative frameworks for health professionals involved in working therapeutically with clients and a clear integrative methodology for assessing, formulating and conducting formal, integrative, psychotherapeutic interventions within the context of healthcare.

# INDEX

- abstinence 77  
Acharyya, S. 31  
action research, psychotherapy  
  as 27  
'affect tolerance' 63, 94  
affective responsiveness 70, 111  
Ainsworth, M. 50  
Aitken, K. 49  
alarm reaction 33  
Alexander, F. 77  
American Psychiatric Association  
  (APA) 30, 34, 84  
Angyal 57  
anti-psychotic drugs 34  
  *see also* medication  
anxiety disorder 13, 46  
Aristotle 26, 47  
assessment, integrative framework  
  for 92–3  
  as collaborative inquiry 88  
  as continuous process 87–8  
  psychiatric diagnosis in 84–5  
  risk assessment 85–6  
assimilation model 38, 158  
attachment theory 50–2  
Atwood, G. 75  
awareness, expansion of 117  
  self- 109  
  
Balint, M. 68, 77, 130  
Barkham, M. 157, 159  
'basic fault' *see* original  
  care-giving relationship  
behavioral and cognitive  
  thinking 27  
Bertalanffy, L. von 57  
Beutler, L. 39  
  
Bion, W. 76, 112, 131  
Boadella, D. 57, 130, 132  
body awareness 113–14  
Bollas, C. 94  
Bowlby, J. 50  
British Association for Counselling  
  and Psychotherapy (BACP)  
  6, 19, 164, 165  
British Psychological Society  
  (BPS) 6, 17, 27, 163, 165  
Brown, G.W. 32  
Browne, D. 31  
Buber, M. 63, 79–80, 115, 124  
Buhler, C. 61  
Burton, M. 85–6  
  
Care Programme Approach  
  (CPA) 84  
Carroll, R. 40  
Carter, J. 66, 121–2  
centring 131  
'character armouring' 56–7  
character rigidity 116  
Chodorow, N. 98  
Clare, A. 29  
Clarkson, P. 66  
client studies, use of 8–11  
Clients  
  Alison 128–9  
  Anne 81, 143  
  Bill 109–10, 111–12, 114  
  Geoff 96–7, 142  
  Jason 98  
  Jean 126  
  Jeremy 99  
  Jill 110–11  
  Jim 46, 52, 59–60

- Clients (*Continued*)  
 Joe 123–4  
 John 133  
 Julie 25, 37, 118, 125, 127,  
 133–4, 135  
 Mary 141  
 Maureen 78–9  
 Michelle 91–2  
 Nick 132  
 Peter 100–1  
 Robert 137  
 Sarah 116, 139  
 Sharon 70  
 Tessa 73, 74, 112, 131, 135  
 Vivienne 125, 138, 140
- client's story, listening to 90–2
- clinical governance 23
- cognitive analytic therapy  
 (CAT) 38
- cognitive behavioural therapy  
 (CBT) 17, 38, 155, 160
- collaborative inquiry 27, 91
- communication skills 107–9  
 symbolic 117
- Community Mental Health Team  
 (CMHT) 15, 84
- confidentiality 106, 148
- confrontation and challenge 115
- consciousness, nature of  
 52–4, 55–7
- containment 131  
*see also* centring
- continuing professional  
 development (CPD) 161
- continuum models 31–2
- contract  
 in healthcare 22, 86–7  
 in psychotherapy 87  
 time-sensitive 41, 102, 108, 136
- Cope, R. 31
- core conditions, concept of 66–7  
 in therapeutic process  
 103–4
- corrective emotional experience,  
 concept of 3, 41, 75, 77,  
 82, 110, 123, 125  
*see also* reparative relationship
- co-transferences, 126
- counselling 18–20  
 interpersonal transactions 19  
 person-centred counselling  
 approach 16  
 and psychotherapy,  
 distinction 18  
 training standards for 18–19
- Counselling in Primary Care  
 Trust 6
- countertransference 73–4, 128–30  
 characteristic responses of  
 therapist 74  
 realistic responses 74  
 responses to material troubling  
 of therapist 74  
 responses to transference 74
- Damon, S. 22
- depression 13–14, 29, 32, 46  
 clinical 14  
 endogenous 32  
 reactive 32
- developmental second  
 chance 55, 125  
*see also* reparative relationship
- Diagnostic and Statistical Manual  
 of the American Psychiatric  
 Association (DSM-4) 14, 30,  
 33, 34, 84
- dialogical philosophy 80–1
- dialogue 63, 109, 115
- disease model 29  
 Hippocrates definition of 29
- disharmony in self-experience 45
- dissociation 55
- distress 48, 50  
 as change and growth 45–7  
 helping a person in 43–64  
 psychosocial 14
- doctor/patient relationship 16
- Dollard, J. 39
- domains of self-experience 94–101,  
*see* identifying key metaphors
- DSM-4 *see* Diagnostic and Statistical  
 Manual of the American  
 Psychiatric Association
- dual role-therapeutic  
 relationships 19

- electroconvulsive therapy (ECT) 16  
 Ellenberger, H. 26  
 emotional life and consciousness,  
   layers of 55–7  
 empathic attunement 110  
 empathy, definitions of 68–71  
   affective 68  
   basis for inquiry 69–71  
   cognitive 68  
   embodied nature of 68–9  
   emotional connectedness 68–9  
   kinaesthetic 67  
   somatic 68  
 endings 142–3  
 Erikson, E. 57, 61  
 ethical practice 145–66  
   accountability for 162–6  
   best practice 152–3  
   competence 149–52  
   dissenting arguments 159–60  
   efficacy and effectiveness studies  
     in psychotherapy 157–9  
   evidence-based practice 154–5  
   fit to practice 160–1  
   practice-based evidence 159  
   practice of psychotherapy and  
     counselling 145–9  
   RCTs of psychotherapy 155–7  
 eustress 33  
 evidence-based healthcare  
   (EBH) 154, 155  
 evidence-based medicine  
   (EBM) 154  
 ‘expressive method’ 71  
  
 facing 133  
 focussing 88  
 Fonagy, P. 13–14, 22, 26, 28, 35,  
   39, 40, 51, 65, 66, 152, 160–1  
 Frederick van Eeden and  
   Van Rentergen 26  
 Freud, S. 43, 55, 56, 63, 64, 65,  
   71–3, 77, 98, 106, 126, 136  
   drive theory 55  
   Freudian thinking 43, 55, 56,  
     63, 64, 65, 71–3, 77, 98, 106,  
     126, 136  
 Frosh, S. 63  
  
 Gabe, J. 34  
 Gelso, C. 121–2  
 general practitioners 12, 13,  
   15–16, 83  
 Goldberg, D. 13–14  
 Goldstein 57, 67  
 good enough care 49  
 Greenson, R. 124, 127  
 Grotstein, J. 128  
 grounding 132  
  
 Havighurst, R. 57  
 healing moments 79–81, 124  
 Hippocrates 29  
 holistic understanding 33  
 Hollanders, H. 40  
 ‘homeopathic doses’ 41  
 Horvath, A. 66  
 Houston, G. 107  
 Hudson-Allez, G. 36  
 humanistic/existential  
   thinking 18, 28, 47, 72, 140–1  
   tradition 1, 3, 18, 41, 44, 46, 58,  
     72, 77, 127, 149, 160–1  
 Huxley, P. 13–14  
  
 I and thou 79–81, 124  
 identifying key metaphors 93–4  
   in gender identity and  
     sexuality 97–9  
   in infant/caregiver  
     relationship 95–7  
   in social and cultural  
     world 99–101  
 illusions 92–3  
 inclusion 63  
 infant/caregiver relationship, role  
   of 48–9, 51–2, 95–7  
 integrative psychotherapy 41–2,  
   61–4, 87–9  
   contracting 87  
   decisions 88  
   fallibilism 88  
   focussing 88  
   formulation 88  
   sustained empathic inquiry 88  
 intentionality 47  
 interaffectivity 49–50

- internal working models 50, 62  
 International Association of Analytical Psychologists (IAAP) 164  
 International Classification of Diseases (ICD-10) 30, 85  
 interpersonal experience 93, 97–9  
 interpersonal psychotherapy (IPT) 38  
 intersubjective  
   conjunctions 75  
   field 75  
   relatedness, role of 49–51, 61–2  
 intrapersonal experience 93–4  
 introjection 59, 76
- Kahn, M. 74  
 Karasu, T. 27, 39  
 Keleman, S. 132  
 Kendell, R. 32  
 Kindermann, P. 31  
 Klein 59, 64, 69, 75, 138, 140–1  
   theory 57, 59
- Lacan's concept 57–8  
 Levinson, D. 57, 61  
 Lewin, K. 136  
 life-span developmental psychology 60–1  
 listening 62, 90–1  
 lithium *see* medication  
 love 43–4
- McGovern, D. 31  
 McLeod, J. 28  
 Mann, A. 14  
 Maroda, K. 129–30  
 Maslow, A. 57, 67  
 medication 34–5  
 Mellor-Clark, J. 157  
 memory  
   existential 94  
   somatic, embodied nature of 54–5, 62  
 memory and consciousness 52–3, 62, 93–4
- memory systems  
   explicit 54–5  
   implicit 54–5  
 mental disorder, definition of 29–32  
 mental health services, referral to 83–4  
 metacognition 95  
 metacognitive functioning 51  
 Miller, A. 123  
 Miller, J. 70  
 Miller, N. 39  
 mind and body, integration of 33–4, 49, 56–7, 113–14  
 mirror, to 110  
 mirroring 58, 134  
 Money-Kyrle, R. 76  
 multiple memory systems 54–5
- National Institute for Clinical Excellence (NICE) 7  
 National Service Framework for Mental Health 7, 14  
 neuroleptics *see* anti-psychotic drugs  
 New NHS 17, 23  
   1990 NHS Act 5, 23  
 non-psychotic disorders 14  
   in primary healthcare 14–16
- object relations 58–9  
 O'Brien, M. 107, 117  
 Orange, D. 55, 75  
 organismic self 57–8  
 organizing principles 50, 62, 63, 141  
   *see also* RIGS  
 original care-giving relationship 48, 68  
 outcome research 28, 45, 65
- Parry, review 17, 19–20, 23, 36, 37  
 perception 133  
 person-centred counselling approach 16  
   *see also* Rogers, C.

- Pierre Janet 55  
 Plato 26, 47  
 post-traumatic stress disorder (PTSD) 13, 46  
 practice research network (PRN) 159  
 primary envy 138  
 projection 76, 128  
 projective identification 128  
 psychiatric diagnosis 29–32, 84–5  
 psychiatric morbidity 14–15  
   dementia 14  
   mental illness 14  
   non-psychotic anxiety and depression 14  
   psychosis 14  
   schizophrenia 14  
 psychiatry 16–19  
   definition of 16  
   ECT 16  
   psychology, psychotherapy and counselling, difference between 16–19  
 psychic maps 57–60  
 psychoanalysis 18, 54–5, 57, 59, 63, 65, 71–2, 117, 123, 126  
 psychoanalytic thinking 27  
 psychology, definition of 17, 18  
 psychosis 14, 32  
 psychotherapist, definition of 43  
 psychotherapy 28–31  
   behavioral and cognitive thinking 27  
   and change 44–5  
   definition of 26, 65  
   in healthcare 12–24  
   humanistic/existential thinking 28  
   integration 25–42  
   integrative perspective 28  
   mental health services, integrating 21–4, 36–7  
   models of integration in 38–40  
   origin of treatments in 18  
   psychoanalytic thinking 27  
   and the soul 43–4  
   in therapeutic relationship 26  
   Type A, B and C 20  
 psychoticism *see* psychosis  
 psychotropic medication  
   *see* medication; anti-psychotic drugs  
 randomised controlled trial (RCT) 154–8, 160  
 range in self-experience 134–5  
 raw data of experience 2, 47  
   as core of experience 48  
 reciprocal process 75, 80  
 reciprocity 79, 80  
 referral  
   to mental health services 83  
   to psychotherapy 87  
 reflective self function/  
   process 51, 62, 128  
 Reich, W. 43–4, 56–8, 68–9, 78–9, 82, 98, 113, 115, 119, 124, 136–8  
   theories 43  
 reparation, revelation and ripening 76–9  
 reparative relationship 125  
 repetition compulsion 136  
 reprojection 76  
 resistance 78, 136–7  
 responsibility 28, 93  
 ‘reverie’ 76, 112  
 RIGS, representations of  
   interactions that have been generalised 50  
 Rogers, C. 57, 58, 66–7, 69, 103–4  
 Roth, A. 13–14, 22, 26, 28, 35, 39, 40, 65, 66, 152, 160–1  
 Rothschild, B. 40  
 Rowan J. 38, 160  
 Rowsan, R. 145  
 Royal College of General Practitioners (RCGP) 15  
 Royal College of Psychiatrists (RCP) 17  
 Russell, J. 37  
 Samuels, A. 28  
 Schaffer, N. 65  
 Schore, A. 39  
 selective serotonin re-uptake inhibitors (SSRIs) 35

- self-actualisation 57, 80  
 self-care system 141  
   quality of 113  
 self-healing 64, 116  
 self-organizing principles 141  
   *see also* organizing principles  
 self-regulating 21, 116, 138  
 self-regulatory competence  
   *see* affect tolerance  
 Selye, Hans 33  
 senses of self 50  
 social and cultural field 61  
 somatic resonance 68–9  
 Spinelli, E. 99  
 spiritual dimension in  
   psychotherapy 43–4, 80–1  
 Stern, D. 49–51, 68, 94, 97, 130  
 stimulus-response model  
   27, 53  
 Stolorow, R. 70, 75  
 stress 33  
   Hans Selye's definition 33  
 stress-vulnerability models 31  
 Strupp, H. 26, 29  
 suicide 31, 70, 85, 156  
 sustained empathic inquiry 70,  
   88, 105–7  
 symbolic communication  
   117–18  
 Symonds, B. 66  
 systemic thinking 53
- therapeutic alliance 65–6  
 therapeutic contact 19  
 therapeutic contract *see* contract  
 therapeutic frame 105–7  
 therapeutic metaphors 83–101  
 therapeutic process 120–44  
   content and process 120–1  
   guilt and shame 140–1  
   increasing range in  
     self-experience 134–6  
   negativity/negative  
     transference 136–9  
   promoting a coherent sense  
     of self 130–4  
   transformation and change  
     139–40
- working with co-transferences  
   126–8  
 working with the therapeutic  
   relationship 121–6  
 therapeutic relationship  
   co-creation of 41, 123, 126–30  
   core concept 65–82  
   dimensions of 66, 122–5  
   empathy in 67–71  
   intersubjective theory 41  
   multi-dimensional nature of 121  
   reciprocal nature of 70  
 therapeutic skills 102–19  
   affective responsiveness 111–16  
   communication skills 107–9  
   core conditions in the therapeutic  
     relationship 102–4  
   revealing hidden  
     meanings 116–18  
   self-awareness 109–10  
   sustained empathic  
     inquiry 110–11  
   therapeutic frame 105–7  
 Topham, D. 86  
 transference 72–3  
 transmuting internalisations 134  
 trauma 62  
   role of 94  
 traumatic experience 51, 54  
   events 54  
   ruptures 95  
   stress 48  
 Trevarthan, C. 40, 49, 51  
 trust 62
- UK Association for Humanistic  
 Psychology Practitioners  
 (UKAHP) 163  
 unconscious communication 71–81  
   co-transferences 75  
   countertransference 73–4  
   psychic mechanisms for 75–6  
   reciprocity 79–81  
   reparation, revelation and  
     ripening 76–9  
   transference 72–3  
 unconscious processes, origins  
   of 128–30

- United Kingdom Association for  
Therapeutic Counselling  
(UKATC) 19
- United Kingdom Council for  
Psychotherapy (UKCP) 6, 9,  
19, 23, 26, 38, 150, 153, 163, 164
- Universities Psychotherapy and  
Counselling Association  
(UPCA) 19
- Weaver, C. 128
- Wheway, J. 61
- wholeheartedness 44
- Winnicott, D. 43, 49, 58,  
140–1
- working alliance 39, 66, 122  
*see also* therapeutic alliance
- Zetzel, E. 66