

## **The implausibility of researching and regulating psychotherapy**

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Abstract: This paper discusses two current themes in psychotherapy practice - research and registration - in relation to the proposals contained in the UK Government's Depression Report. Psychotherapy is highlighted as an essentially human endeavour than can neither be researched nor internally regulated outside the bounds of self interest. Nor can it conceivably produce the results that the Depression Report promises.

In the end of course research into and the registration of psychological therapies, at least those relying on conversation, is an absurdity. For the British Psychological Society's Division of Clinical Psychology and other bodies with vested interests, these are absurd ends pursued with relish. (e.g., Turpin, 2006)

Critically, conversation-based therapies require informed consent of all parties. If you are aware enough to consent to a conversation, then you already know that conversations can go anywhere with an infinite variety of putative outcomes. Even the concept of "outcome", so beloved by researchers, is nonsense. You finish a course of therapy and feel better or worse. Is that the outcome? Only if you drop dead at that moment. As a living being continually open to external influence, the second a therapy client leaves the room new things happen. The point at which we decide an

outcome has been achieved is wholly random and unlikely to reflect anything other than the intrinsically dull mores of the 21<sup>st</sup> century – feeling happier, being more productive, feeling less stressed, no longer being troubled by voices and the rest. As the client enters into the therapy contract the designated expert will be likely to say that providing you stick to the formula the particular outcome will be a desired one; an increase in self esteem, a reduction in worrying over minutiae, whatever. The formula may be Cognitive Behaviour Therapy (CBT) homework diaries, free association with a Freudian analyst, submitting to the violent vagaries of provocative therapy, anything up to a 1000 different supposed vehicles for change. But the chances are that, as an adult, you are already aware of that most notorious of “just stick to the formula” promises - weight loss. Every known diet fad promises weight loss on condition you stick to the formula, whether it be calorie counting, eating nothing but vegetables or avoiding anything not mentioned in the Old Testament (see Paul Theroux’s *Millroy the Magician* for a fictional account of Kellogg’s success: Theroux, 1993). The problem, as we all know, is that people don’t stick to diets (I once calculated that in 60 years of dieting my mother had lost in excess of two tonnes – and put back on slightly more). People have lives to lead, habits to maintain, even an understandable distrust of miracle cures based solely on will power. So, with a degree of relief and relish, people go back to eating fast food and give up the latest version of pilates/aerobics/paragliding. Talking therapies are no different. You can religiously keep thought diaries, create complicated diagrams featuring snags, traps and dilemmas, or sign up to two years with an analyst making obscure (and, frequently, obscene) comments about your unconscious desires but the kind of will power necessary to sustain such activity in the face of ordinary life as it pushes you around is only possessed by those requiring no such treatment. And that assumes the existence (beyond the words themselves) of “will power” (see Sartre cited in Smail, 1979).

No doubt a hermit would have less trouble with sticking to the formula. After all, a hermit doesn’t face the daily distraction of family and friends (or enemies), the constant orthodoxy of TV advertising (it’s all advertising – especially the so-called “news”) or the regular Big Pharma sponsored press announcements concerning yet another cure-all. Similarly, hermits don’t have a therapist, a real person, sitting with

them. And there's the rub. Conversation requires another person. Professional, therapeutic conversations require one person to be designated an expert – and experts don't have good press, despite their PR agencies. Just think of the last time (probably this morning) a degree-laden meteorologist got the weather wrong when all she had to do was look out of the window. Conversation with a designated expert (especially one who claims, utterly vacuously, that you, the patient, are the real expert) is bound to include doubts, judgements, and an awareness that the expert doesn't live your kind of life – unless your life involves a well paid job based on chatting to people. Even if the therapist appears to be not so different from you in terms of culture, class, and troubles there is absolutely no-one out there who is faced with the same circumstances, physiology, relationships, family past, present and future with which you struggle.

So-called experts in psychology are particularly easy to dismiss. In claiming some kind of knowledge and expertise in human relationships, we should be pretty healthy, no? No. Any professional psychologist can name people they work alongside regarded as nasty, hung up, mean or just plain bonkers. Over the years, as drug company propaganda and fashion dictate the latest diagnosis to be a “world endemic”, professionals queue up to tell us of their diagnosed depression, obsessionality, voice hearing; even Attention Deficit Hyperactivity Disorder (see: Newnes, Holmes and Dunn, 1999; Wallwork, 2007). Far less public have been the revelation of Freud's affair with his sister-in-law, Martha Bernays, Jung's liaisons with his patient, Sabina Spielrein, or the fact that over half of Freud's select circle of fin-de-siecle psychoanalysts killed themselves. An acolyte of Freud, Melanie Klein, who founded child psychoanalysis had a daughter who found her upbringing so appalling, she wrote extensively about her mother (Grosskurth, 1994). If you are keen to question Carl Rogers, Fritz Perls and other so called humanists, look no further than Jeffrey Masson's (1989) *Against Therapy*.

How about your narrator? I'm pretty well qualified. A Director of Psychological Therapies with over 30 years' experience, past Chair of the BPS Psychotherapy Section, possessor of no less than three degrees and the longest serving member of the Division of Clinical Psychology's national committee as well as editor of its national

newsletter and the Journal of Critical Psychology, Counselling and Psychotherapy. Therapized to the point of no return too. Yet it took a near fatal road accident for me to have a proper conversation with my dad: I was 51, my dad 76. True to Newnes style, the conversation has become a book on my dad's experiences during the Malaysian Emergency from 1948-1951 (Newnes and Newnes, in prep). It took the birth of my first daughter and an overwhelming respect for her mother to overcome my fear of house spiders. Friends could list many fears and foibles. Here are two only a few people know about. First, I get upset if we run out of loo-blu for the toilet (how sad is that?). Second, I'm incapable of walking past a house plant that needs watering. So how good at overcoming fears and so on am I, Mr Expert Ologist?

As a patient the best you can hope for is that the therapist has a modicum of sympathy for your plight and isn't too demanding when it comes to those thought diaries and complicated diagrams. You might hope that the therapist sticks to the script and doesn't start seducing you or berating you (though there are therapies that suggest both courses of action as therapeutic). Government calls for evidence based therapies or professional attempts at registration appear to be aimed at reducing the likelihood of these all too human eventualities. Such appeals are enormously problematic. Rogerian counselling, for example, is, almost by definition, seductive. A calm, apparently concerned, adult spends ages listening attentively to what you say, then, at least according to stereotype, quietly reflects back some of your words. This can go on for hours every week. It might be the only time anyone seems to take you seriously. That's pretty seductive (Ward, 1993).

No system of registration or practice based on researching what others claim to do or achieve in therapy can guarantee that your therapist's chosen modus operandi will lead to change in the desired direction. Neither a registered therapist nor a well researched therapy can create the necessary conditions for you to concentrate on your various therapy homework assignments. Nor can that therapist move beyond self interest (Smail, 2006). If she is in training she is likely to stick to the prescribed method, no matter what. One possible result of such persistence is that both people end up with a sense of failure – not so bad for the therapist in training who will have other fish to fry, but not great for the client, already convinced that most problems are

of her own making. More experienced practitioners will deviate from the script, offering a range of comments aimed at getting the recipient back on course. Such comments create an identifiably more human connection. Once we enter the realms of the human a host of other factors come into play including, potentially, the dreaded (longed for?) seduction or hostility. It would be an extraordinarily inhuman therapist, in training or long-qualified, who kept to the script. It just isn't possible (you would hope) to exclude all human variables. Computerized Cognitive Behaviour Therapy attempts to do just that, as if all potential clients are reasonably au fait with computer technology, don't have buses to catch in order to get to the computer terminal on time or don't know where the off switch is. Relationships between people, however, are grounded in a plethora of imitated and learned conduct. We lie, smile, cheat, demur, agree, stare and avert our eyes in a constant social dance. If the room is hot, we have recently stubbed our toes or the medication is making us feel sick, the dance steps change accordingly.

At its simplest, it goes like this. A therapist, assuming him or her to be of altruistic bent will act with a degree of kindness towards the client. Sensing the presence of a person that cares, the client acquiesces, agrees, looks first down-cast, then encouraged and, quite unwittingly, gives the impression that the therapy might be an answer. Both people leave the room feeling a little better about life. The client even understands that the session lasted only an hour, not because the therapist was bored, but because 60 minutes (or minor variants) had been agreed. So far, so good. Except that in this encounter all we can infer is that both parties acted in a social, indeed frequently sociable, manner. Should we take the trouble to perform a Conversational Analysis (Sacks, 1989) on what occurred we shall be no closer to discovering if the client has any intention or real opportunity to carry out the first post-session task, whether it be recording a dream or writing down anxiety-provoking thoughts. We might know that the client has a long history of saying the right things to people in positions of perceived influence. Like the rest of us, she consistently fails to do things she has agreed to try out – from dieting to using a vibrator. The next encounter is, again, positive. This time the therapist makes active efforts to explore why the client has failed to fulfil the agreed task. Misunderstanding? Resistance? A domestic emergency, perhaps? The simple rough and tumble of everyday life? The therapist

remains concerned and caring. And, by definition, in the social game being played, seductive. Three sessions later, in a burst of insight, the client says she always agrees with people she thinks are positioned as powerful. Indeed, the therapist had suggested as much quite early on. But it's a stalemate. Is the client saying this because she thinks it is what the therapist wanted to hear? We have no way of knowing. But we do know that the majority of people don't fill in thought diaries, a sizeable percentage can't write and many crave the kind of care therapists promise. So therapy is maintained, at no great cost to the client and to some financial advantage to the therapist.

Such a scenario may be untypical of therapy. Therapy relationships are shaped by many variables. The client or therapist may be a regular smoker or drinker (alcoholism rates amongst General Practitioners bear some examination here). Is the therapy financed by the State or is the client paying direct? The client may be on a compulsory treatment order or under such pressure from the family attend sessions that she does so. The imagined worst case scenario is of an unregulated, barely trained therapist, carrying out half remembered versions of CBT while charging someone with little money for the privilege. But we have no idea of what the outcome of such an encounter might be. Initially down-hearted, the client may, in a burst of righteous indignation, stop attending or if under compulsion simply refuse to speak. Either action will lead to a different, potentially more useful, relationship. Equally, therapy might end there and then. It hardly matters. The ex-client will now have some room in life for a person who isn't paid to be there. Knowing that a relationship has been based on one person's financial gain does little for our sense of self.

### **The Depression Report**

The Depression Report acts as if all this is irrelevant. Apparently people will be able to change life-time habits, their conduct and even their sense of fulfilment by chatting to the right kind (CBT) of therapist. That therapist will have a relationship (called supervision) with someone more qualified than themselves who can offer guidance in the best ways to interact with a person (the client) who the supervisor may never meet. That supervisory relationship will somehow rise above the social dance that

characterises the therapist-client relationship. The grateful therapist will respond to supervisory wisdom and instruction and behave differently with the client in the client's best interests – as perceived by the supervisor. The therapist won't let concerns like the supervisor's dress sense, preferred hair style, lack of children and the rest get in the way. After all, the supervisor is also registered and prone to quoting Layard on evidence based therapy practice.

If we are serious about informed consent some of the less publicized research should not slip by us. For example, Eysenck (1952) surveyed nineteen reports on the results of psychotherapy (just over 7,000 patients) including five reports by psycho-analysts (about 750 patients). He concluded that the statistical uselessness of the reported information 'highlights the necessity of properly planned and executed experimental studies into this important field'. So, believing what people say just isn't good enough. Eysenck went on to suggest that two thirds of people in distress amenable to psychotherapy spontaneously recover; about the same proportion who are said to benefit. This makes sense. Relationships have a kind of three outcome rubric "A third make you feel better about life, a third worse and a third don't affect you." Eysenck's critique seemed to fundamentally challenge the *raison d'être* for the predominant therapy around in 1950s' Britain – psychoanalysis. The analysts fought back, ideologically and methodologically. A key finding was brushed under the carpet - in addition to a small percentage of clients claiming spectacular success for therapy, roughly the same proportion (5%) felt a lot worse. Many killed themselves. The same is true for the early, now carefully ignored, days of Family Behaviour Therapy for so-called schizophrenia where a quarter of the identified patients committed suicide (Leff, 1983). Eysenck paved the way for the behavioural and, later, the cognitive behavioural revolutions in psychotherapeutic practice. The latter is championed in the Layard report as a good way to get people back to work and off State benefit. Research into CBT is upheld as of the most sophisticated type and clearly indicative of success. The Depression Report has been much criticised methodologically and ideologically by professional researchers and those, like Engels (1844/1988), who know that getting people back to work actually means getting folk into jobs that are soul-destroying (and frequently poorly paid). I shall limit myself to critiquing one aspect of the research favoured by Government Quangoes of the Layard type. The

critique is based, again, on the way self interest is revealed within the preferred methodology.

Layard's report leans on the Department of Health's (2001) previous document, *Treatment Choice in Psychological Therapies and Counselling*. This earlier document categorises research based evidence as follows: meta-analysis, randomized controlled studies (RCTs), controlled studies, quasi-experimental studies, descriptive studies and "expert committee report on clinical experience". The least favoured research types in terms of funding recommendations for therapy are the last two. The first two, meta-analysis and RCTs are regarded as the strongest guides to recommending State or insurance-based funding for therapy. It is possible to criticise such a hierarchy of approved methodology from virtually any perspective; recipient report is simply not mentioned, the usual guide to a Capitalist analysis, the market, is ignored and if you are interested in what people will actually pay for, then physically based psychotherapies do rather well, RCTs replicate the drug metaphor in therapy ("Your condition is X, you need ten sessions of Z"), only vast academic and frequently drug company sponsored institutions can carry out meta-analysis or RCTs and the people researched live utterly different lives from the people receiving National Health Service therapy...the list goes on. The expert consensus on which the expert committee report is based, however, deserves special mention. Here, eight "clinically realistic" (though wholly fictional) vignettes are presented to a panel of experts. The vignettes are medicalized giving us typical pictures of "Depression", Anxiety Disorders", Eating Disorders", "Personality Disorders" and "Somatic presentations." Further the vignettes assume, a) there is equal access to all therapies (and waiting time is not a factor), b) all therapies are delivered by competent therapists and c) there is optimal medical management. I defy anyone to find one area of the United Kingdom where one of these assumptions is valid. Notwithstanding my churlishness, the next part of the process, the expert consensus, is the supreme folly. At this point a group of therapists of different persuasion argue about which therapies are best for which difficulties. Like the Caucus race in Alice in Wonderland, and unsurprisingly, all represented therapies get a slice of the State-funded clinical cake.

The Depression Report takes this further and centres on Cognitive Behaviour Therapy. Again, all shall have prizes. Patients can dance socially with interested, frequently kind, experts, clinical psychologists will justify their salaries by becoming supervisors of a burgeoning army of less well paid therapists, a percentage of patients will indeed come off State benefit (only to go into awful jobs – but you can't have everything), drug companies will have reinforced the drug metaphor for helping distressed people and editors of journals like this will have more copy. And all the while pretending that there is actually something wrong with people who go into this thing called psychotherapy and some of us are experts in the human condition.

The Layard panel manages to neglect a huge range of psychotherapy research. We know for example that some therapists, especially the registered ones, do indeed have sex with their clients, that all therapies have been shown to be equally effective and that those that best respond to talking therapies - the single, the verbal, the articulate, those deemed intelligent and those lucky people with supportive family resources – barely need therapy at all. None of this answers the only question your client would ask if they dare – will this therapy help *me*? At this point the more scientific therapist will retreat to an appeal to statistics, “On average, two thirds of people in similar circumstances show a decrease on their score on the Beck Depression Inventory”. Therapists more attuned to the power of placebo will be less vague: “I have every confidence you'll feel better soon”. Such a statement is a double-edged sword. As the client slithers into despair in ensuing weeks, or fails to feel much different she will now know who is to blame – herself, after all it can't possibly be the therapy, because most people respond. Layard and his colleagues don't address such awkwardness because the Depression Report isn't about people feeling better, moving on, self actualising or the rest. It's about claiming to get people back to work and off benefits. Someone with a potentially life-changing spell of madness or mortifying sense of anomie will be funnelled into a job with the kind of pay and conditions of service the therapist left behind long ago. Therapists in Layard's brave new world become an arm of the state-serving bourgeoisie in a far more explicit way than before. In effect, they are paid by the State to make sure people remain cogs in the machine rather than giving them a collective voice on the parlous state of modern society. Generally, its not that parlous for those who wrote the Depression Report. A mixture of academics,

policy makers and economists, their material lives are probably fine. Most believe they act for the best interest of others and jobs are good for people. They should try working in a call centre – the factories are all closed.

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