

THE CASE AGAINST Psychotherapy Registration

A Conservation Issue for the
Human Potential Movement



Richard Mowbray

The Case Against Psychotherapy Registration

Is psychotherapy a suitable case for statutory treatment? This book responds with a resounding No!

A thorough investigation of the case for a 'protected' profession reveals a tale of flimsy historical underpinnings, professional and political shenanigans and vested interests.

In this careful appraisal, Richard Mowbray explains why a conventional licensing system would be inappropriate, ineffective and actually harmful to the public interest. Licensing would also marginalize the human potential movement or submerge its message beneath the dominant world-view of remedial treatment.

This resourceful guide provides detailed information on the whole tangled question of registration and offers a solid basis for rational debate. International comparisons and examples from already established professions give additional perspective to this key issue.

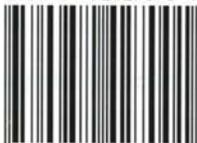
Constructive proposals are offered for viable, practical and holistic alternatives to conventional licensing, along with clear recommendations for conserving the vitality of the human potential movement.

This book is essential reading for anyone concerned about the future of psychotherapy, counselling or personal growth, and anyone interested in the impact of licensing systems on our society in general.



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Mowbray



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This book is dedicated to Bill Swartley who led the way,
Juliana Brown with whom I travel
and my clients, *sine qua non*.

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Preface

This book started life in 1993 as an idea for a paper or booklet intended as an attempt to forestall what I then saw to be a risk of imminent legislative endorsement of UKCP, the presumptuously titled United Kingdom Council for Psychotherapy. Then, as now, my deepest concerns were with the impact this would have upon the human potential movement and its capacity to promote personal and social transformation. An 'inevitable' advance towards statutory control was widely touted at the time and in the face of this prospect, a climate of compliance and passivity, if not support, prevailed amongst practitioners. Apart from a few critical articles, there was little protest, even from the humanistic world.

As I delved into the issue, however, it became apparent that the risk of legislation was in the medium or longer term rather than an immediate prospect and this realization allowed me to reassess, broaden and internationalize the objectives of the project. Moreover, the more I discovered about the issue, the wider its ramifications and the deeper its significance appeared to be.

Consequently, although its imminent arrival had already been announced in some quarters, this project developed something of a life of its own and continued to grow into the more comprehensive study which you now hold. Even as 'vapourware' however, it seemed to have been doing some good by publicizing the fact that there actually *is* a case against psychotherapy registration - a fact that seemed to have escaped the notice of many people.

This project would have come to nought, however, were it not for the shared world-view and endless support and encouragement of Juliana Brown whom I must thank for tireless feedback, painstaking editorial, research and administrative input, and for the splendid cartoon that graces the cover. In many respects this project is as much hers as mine.

I am also very grateful to all those friends, colleagues and clients who have helped the project on its way with encouragement, with information, with feedback, with criticism of the drafts and with other support of various kinds. Particular thanks are due to Silke Ziehl, Kate Wylie, Christine and John Woodruff, Lola and Peter Wilkins, Mike Wibberley, Eric Whitton, Annie Sullivan, Mike Shackleton, Tony Pinchuck, Barbara McCrea, Murray Mahon, Betty Hughes, Guy Gladstone, Sandra Evans, Basiro Davey, Hyone and Tony Criscuolo, Wilma Brown and David Babsky.

I also owe a special debt of thanks to Daniel Hogan for his inspiring study of psychotherapy regulation and for permission to quote portions therefrom.

I am also grateful to all those others whose views on this subject I have referred to herein and to which I hope I have done justice.

I also wish to acknowledge the journal *Self and Society* which - as a “channel of communication for the human potential movement” - has been one of the few forums where the issues addressed by this book have been actively debated.

Last but not least, my thanks for the VW Beetle of computing - the Tandy 100 (Super Rom equipped), the marvellously simple and distraction-free writing machine with which much of this book was written. It may not be fast but it gets there.

Please note that the following convention regarding emphasis in quotations has been adopted in this book: emphasis in quotations is in *italics* if present in the original and in ***bold italics*** if added by myself.

Introduction

The Emperor's Wardrobe

... a veritable Emperor's wardrobe of nonsense.

(David Wasdell, 1992:5)

During the 1990s, the practice of psychotherapy and counselling has attracted a great deal of adverse publicity. Tales of sexual exploitation, false memory implantation or other dubious activities have become so common in the media that one could be forgiven for thinking that this is a very hazardous activity indeed, perhaps carrying risks comparable to those that have so often accompanied drug-based approaches to personal problems whether 'professionally' or 'privately' prescribed.

Alongside this clamour, calls for statutory regulation to curb the 'menace' posed by 'unqualified' psychotherapists and suchlike practitioners have become more strident in the UK.

In this climate, the United Kingdom Council for Psychotherapy (UKCP) came into being and has established a voluntary register for which it seeks statutory endorsement. Other large organizations in the field have also shown interest in statutory approval for their registers. Psychoanalytic bodies including the British Psycho-Analytical Society have set up their own register under the aegis of the British Confederation of Psychotherapists (BCP). In conjunction with other counselling organizations, the British Association of Counselling (BAC) is pursuing a register for counsellors. The British Psychological Society (BPS) has had a register since summer 1990 which, through the system of Crown privilege, already gives its members a form of title protection over the term 'Chartered Psychologist'. They also aspire to statutory control of the term 'psychologist'.

So far, the UK government has not been persuaded to introduce legislation to endorse any of these registers. In my opinion government would be very ill-advised to do so. However, such is the general lack of aware-

ness of the arguments against such a move that governmental compliance might eventually be forthcoming. This book is an effort to forestall that situation by raising the level of awareness of the issues involved and presenting the case against such statutory validation.

In 1990, following on from a special issue of *Self and Society* on the subject of psychotherapy registration,¹ my colleague Juliana Brown and I wrote an article for *Self and Society* (see Appendix A) which expressed our misgivings about the proposed formation of a ‘profession’ of psychotherapy via the registration of psychotherapists as embodied in the United Kingdom Standing Conference on Psychotherapy (UKSCP, the forerunner of UKCP). We were particularly concerned about participation in this process by organizations associated with the human potential movement. We also offered alternative proposals based on empowering the public to make informed choices via ‘full disclosure’ provisions. We felt that these alternative proposals were more in tune with ‘human potential’ values than the proposed registration schemes.

The response that we received from some of those spearheading the involvement of humanistic organizations in the process of registration ignored the substance of what we had to say and the alternative proposals we had made and instead seemed to focus on the fact that we had criticisms at all!² This reaction did not inspire us with any greater confidence that a beneficial process was under way and prompted us to look more closely at what was going on. Our resolve in this regard was strengthened by discovering that the most comprehensive exploration of the whole business of psychotherapy regulation to date had come to conclusions not far removed from our own - including a support for ‘full disclosure’ provisions. This four volume study undertaken at Harvard by Daniel Hogan (1979) seems to be rarely referred to despite its importance. The arguments presented in this book owe a considerable debt to Hogan’s work.

In my view, proposals for the accreditation and registration of psychotherapy are most usefully addressed as part of a political process concerned with power and control and it is this perspective that informs much of this book. Insights as to the unconscious dynamics underlying this process (e.g. Waddell, 1992) are valuable, but are of limited practical use unless those actively engaged in, or passively going along with, this process are ‘ready to receive the interpretation’.

UKCP has acquired a bureaucratic momentum and a 'bandwagon' has begun to roll, driven I think more by fear and fatalism than by wisdom. Practitioners are seeking access to its register out of concern for their future right to practise or for fear that otherwise their stream of referrals may dry up. Training organizations (who form the bulk of UKCP) are climbing aboard to give their courses a 'respectable' status for fear of losing out in the competition for trainees. Would-be trainees are in a situation particularly prone to these fears as they ponder which course to invest in for their future.

In the course of writing this book, it has become clear to me that there is nothing inevitable about these proposed restrictions becoming law. In fact, the beliefs that have inspired all this fearful contemplation are largely unfounded. Neither the UK government nor the European Community/Union institutions have expressed any intentions of making legislative changes regarding the activities of psychotherapists. Nearly all the pressure for this has come from the psychotherapists themselves or professions with an overlapping sphere of interest, aided and abetted by media 'horror' stories.

The establishment of a statutory register of psychotherapists in the UK would in my view have a significant detrimental impact on the working environment both for 'psychotherapists' and for practitioners in the human potential field. In a climate of fear and false rumours, where what registration advocates *wish* to be the case has become confused with what *is* the case, the establishment of what is merely a voluntary register by UKCP has already had a deadening effect on practice, training and innovation.

It is important to note that the practice of psychotherapy and other forms of related work, although not subject to statutory professional regulation, is not totally unregulated in the UK. Under common law there exists a right to offer such services for payment, and to call yourself a psychotherapist if you wish to do so (or spiritual healer or whatever). This right is however subject to the same laws (of contract, trade description, etc.) that regulate the provision of any other service.

Britain provides a uniquely open milieu which is in my opinion more conducive to the healthy development of personal growth work and psychotherapy than the restrictive situation which the 'therapy bureaucracies'

seek to impose. The legal framework for practice is not in need of remedial ‘treatment’ and moreover provides an important example for other countries already saddled with inappropriate legislation. If legislative restrictions such as sought by UKCP et al. are to be introduced in Britain, the onus should be upon those who favour this change to prove the necessity and to substantiate their position that the restrictions they seek would be beneficial. I am of the opinion that the case for statutory registration in this field does not stand up to scrutiny. As I will endeavour to show, whilst at first sight statutory registration may appear to be a sensible idea, the balance of available evidence indicates that in all probability it would do more harm than good.

Although this book tends to focus on UKCP and its schemes, the arguments presented are in most cases equally relevant to the pursuit of registers by the other organizations mentioned above and indeed registration schemes in this area generally, whether in Britain or elsewhere.

Proposals for psychotherapy regulation bring into sharp focus the relationship between the human potential movement and the worlds of psychotherapy and counselling. A major concern of this book is to present a case for the maintenance of a clear boundary and appropriate terminological differentiation between human potential practice and psychotherapy with a view to the conservation of a broadly based and thriving human potential movement. I hope to raise the general level of awareness about this issue and to challenge the involvement of humanistic organizations in bodies promoting statutory registration.

The issues addressed in this book go beyond those of a parochial professional squabble. They concern the interface between the spheres of the personal and the socio-political. Insofar as some of the activities involved are intended as systems for personal growth and transformation, the role of the state in relation to these bears comparison with issues of artistic, religious and educational freedom.

In 1660, John Bunyan, a tinker, was arrested for unlicensed preaching. He was imprisoned in Bedford jail, where he remained for twelve years and was subsequently to write *The Pilgrims Progress*. He died in 1688 whilst in London to preach and was laid to rest in Bunhill Fields, the great London burial-ground for religious non-conformists.

Section I

Psychotherapy

A Suitable Case for Statutory Treatment?

Chapter 1

The Terminology of Regulation

Terminology in the field of licensing is confusing....

(Daniel Hogan, Vol. 1, 1979:237)

What is ‘accreditation’? What is ‘registration’? Some dictionary definitions will help to get us under way. According to *The Shorter Oxford English Dictionary* (3rd edn.), ‘Accreditation’ is: “the action of accrediting” leading to somebody being ‘accredited’ or “furnished with credentials; authoritatively sanctioned”. ‘Credentials’ are “letters or written warrants recommending or entitling the bearer to credit or confidence”. *The Concise Oxford Dictionary* (4th edn.) defines ‘accredited’ as: “officially recognized (persons); generally accepted, orthodox (beliefs)”.

Note that ‘accreditation’ has an implication of being able to take someone on trust as a result of ‘official’ recognition. ‘Accreditation’ in this area is usually understood to refer to some form of ‘official’ approval to practise through having met certain standards or having fulfilled certain requirements. ‘Registration’ is: “the act of registering or recording” (*The Shorter Oxford English Dictionary*, 3rd edn.) and in this context usually refers to the process of registering those with the required credentials.

Daniel Hogan has surveyed the terminology in this area as follows:

Terminology in the field of licensing is confusing. To illustrate the definitional problems involved, laws that forbid people from practicing without a licence have been referred to as licensing laws, mandatory licensing and practice acts [and in the UK, ‘functional’ regulation or registration (Sieghart, 1978)], while laws that only forbid the use of titles have been termed certification laws, permissive licenses, or title acts [and in the UK, ‘title protection’, ‘indicative’ regulation or registration (Sieghart, 1978) or ‘nominal registration’]. Both types are frequently referred to

as licensing or licensure laws [and in the UK, ‘statutory regulation’ or ‘statutory registration’]. In addition, laws that do not require a practitioner to meet certain standards but do make registration mandatory are termed registration laws, and are also generally considered a form of licensure. (Hogan, Vol. 1, 1979:237)

Hogan goes on to outline how he uses the terms in his study:

For the sake of consistency and conceptual clarity, laws that forbid the practice of a profession without a license and require meeting certain minimum standards will be termed *practice acts*. Laws that require meeting certain minimum standards to use certain titles, but which do not restrict the right to practice will be referred to as *title acts*. Those laws that only require registration with a state agency and do not demand the successful completion of an examination or the meeting of other minimum requirements will be referred to as registration laws [see below]. *Licensing* and licensure will be used interchangeably and will include both title and practice acts and registration. The term “certification” will be reserved for nongovernmental associations and their efforts to determine whether practitioners have met certain standards of competence, which may be either minimal or maximal. Accreditation will be defined as the process a governmental or nongovernmental agency undertakes to determine whether an academic or nonacademic training institution or program meets certain standards. (ibid.) [Emphasis added.]¹

Note that Hogan uses ‘certification’ where an organization is validating an individual practitioner and ‘accreditation’ when it is the training organization that is being validated. In the UK such a clear distinction is not commonplace so reference is also made to individuals being ‘accredited’. Furthermore, a distinction between training ‘certification’ seen as a qualification to practise and ‘accreditation’ seen as a renewable licence to practise, has been promoted within UKCP (Young, 1990:6).

Writing in a North American context (with a Canadian focus), Trebil-

cock and Shaul (1982:285) maintain a distinction between ‘certification’ (reserved title) systems, that is title acts, and ‘licensure’, used only to refer to practice acts. The Association of State and Provincial Psychology Boards (ASPPB), again in a North American context, adopts a similar position:

When both the title and practice of psychology are regulated, the law is called a licensing law; when only the title of psychologist is regulated, the law is called a certification law. [However to avoid redundancy where both are being discussed] ... the word “licensure” will be used to stand for either licensure or certification. (ASPPB, 1994b)

The use of ‘certification’ and ‘licensure’ as distinguishing terms seems to be quite common in North America. However, as in the case of ASPPB, the simultaneous use of ‘licensure’ to refer to both types of law can lead to misunderstanding.

In the UK, the term ‘registration’ has been used in the sense of a *voluntary* register, that is one without legal backing or in the sense of a *statutory* register which does have legal backing. The difference is not always made clear, in news reports for example, and this has led some people to erroneously suppose that a legally backed register for psychotherapy already exists. Both voluntary registration and statutory registration are consequential on the certification of the practitioner by some accredited body or other, but only in the case of the latter is registration equivalent to what Hogan calls a ‘title act’ if it applies only to title, or a ‘practice act’ if it controls the activity as well.

In this book, for the most part, I have tended to adopt the terms *practice act* and *title act* since I think they offer the most explanatory value. The term *licensing* will be used to cover both types of statutory control. Note that *practice act* should generally be taken to mean that titles are protected as well as practice.

In contrast with the usage in the UK, the ‘registration laws’ referred to by Hogan do *not* require any prior credentials for registration, and for the sake of clarity I will refer to them as *non-credentialled registration*. The issue of *indirect regulation* will be addressed mainly in Chapter 20.

Chapter 2

Some Stated Justifications for a Psychotherapy Register - and Some Refutations

The reasons put forward by Courtenay Young [Jan. 1990] and others to justify these moves towards regulation and licensing include: “protect the public”, “definite status and legality”, “official recognition”, etc. Whatever the validity of these reasons, (little we feel) in our view the ‘cure’ is liable to prove worse than the ‘disease’.

(Juliana Brown and Richard Mowbray, 1990:32)

... it’s argued that, to stay autonomous, we have to ‘put our house in order’ and establish ourselves as a defined profession.... So is our house really ‘out of order’? Psychotherapy in Britain proceeds in a thoroughly self-regulated fashion which throws up some anomalies, some misuse of power and certainly some inefficiency, but which may well be a much better vehicle for the activity than any central organization. It seems that the new control initiatives will seriously deform psychotherapy - in fact, they have already started to do so.

(Nick Totton, 1992:26-27)

Stated justifications for the establishment of UKCP and the registration of psychotherapists tend to be either of the sort that claim this would represent some sort of *improvement* on the existing situation for the public or practitioners, or those which claim such developments are necessary *defensive strategies* against worse situations arising for practitioners.

Arguments for psychotherapy registration which hold that it would represent an improvement are as follows:

*Some Stated Justifications for a Psychotherapy Register -
and Some Refutations*

Remedy the ‘disorder’ in the field

Justifications are sometimes couched in terms of reducing ‘fragmentation’, putting houses in order, clearing up messes, or standardizing hotch-potches:

The point of accreditation, as we spelled out at the time [1980 - founding of AHPP - the Association of Humanistic Psychology Practitioners] was to put some structure into a disorganized field which had become quite messy. We felt we wanted to put our house in order, so that we could say to all and sundry that there were some decent standards of practice.... (Rowan, 1991:32)

... the implications of what it means to have a profession of psychotherapy, rather than the present hotchpotch of variously trained people from a great variety of backgrounds and disciplines who cannot agree on very much common ground. (Young, 1990:4)

This state of ‘the field’ could, from another point of view, be seen as diverse, decentralized, deregulated, ‘grass roots’ and fostering emergent order rather than requiring order imposed upon it. (See e.g. Horrocks, 1990:56.) Le Corbusier’s plan for the redevelopment of the Right Bank in Paris comes to mind: “He proposed to replace the genial disorder of the Rue de Rivoli, les Halles and the Faubourg St. Honore with a grid of cruciform tower blocks. He argued: ‘Imagine all this junk, which has until now lain spread out over the soil like a dry crust, cleaned off and carted away and replaced by immense crystals of glass’ ” (‘Centipede’, 1993). Thankfully, his wish was not granted!¹

Form a profession of psychotherapy

Hand in glove with the above concern with standardizing is the urge to establish psychotherapy as a ‘profession’, notwithstanding Freud having once dubbed psychoanalysis as an ‘impossible’ profession (Freud, 1937). Holmes and Lindley, for example, hold that:

The Case Against Psychotherapy Registration

... A psychotherapy profession is needed if the cacophony of one-man bands is to be harmonized for the benefit of the would-be patient. (Holmes & Lindley, 1989:217)

Since UK governments have proved consistently reluctant to legislate in such a diversified area as this one, the goal of a statutory register is both a means and an end to this process of forming a unified profession (ibid.:207).

Comparisons are made with occupations that already have statutory recognition and which psychotherapy might emulate:

It is also worth at this point, saying what is meant by a profession. A profession, like that of an accountant, solicitor, or architect, has a definite status and legality. There is official recognition.... (Young, 1990:4)

Whilst accepting that there is great diversity in the activities of the different professions, Trebilcock holds that there are common elements as well:

In each case we find the application of a body of knowledge that is systematic and sometimes arcane. This is a knowledge which, by its very nature, can be acquired only by long and arduous training.... the essence of a professional relationship involves the assumption of an *agency role* by the practitioner, acting on behalf of all the relevant interests involved in the decision making, i.e. the client's interest and those of third parties.... (Trebilcock, 1982:101)

Thus members of professions generally act as agents for their clients, carrying out for them tasks that they would not have the knowledge base to perform. I think that equating psychotherapy and even more so human potential practice with such professions is very misleading. Whilst the acquisition of an elaborate body of professional knowledge may be fundamental to competence in the typical profession, there is little reason to suppose that basic competence in psychotherapy or human potential work is founded on a similar basis.

Some of those who favour the establishment of a psychotherapy pro-

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and Some Refutations*

profession acknowledge this difference - and the difficulty this poses for that goal:

One hallmark of a profession is that its practitioners have technical knowledge and skill that do not exist, or exist only in rudimentary form, outside the profession. This creates a problem for psychotherapists whose skills, being to do with people rather than things, and with people as people, rather than people as things, can be hard to specify as compared, for example, with those of an architect or chiropracist.... (Holmes & Lindley, 1989:210)

For some, the way this activity should be socially organized, that is, whether it should be regarded as a profession or otherwise, is a matter crucially related to the goals of the activity itself. Nick Totton sees the matter as follows:

This central fact [that any value in psychotherapy resides in the quality of the meeting between two individuals] reveals psychotherapy to be quite a different activity from the professions with which it is now being compared. It starts to explain the radical thrust therapy so often shows in practice: How to move people away from social norms and conformity. It suggests strongly that the best therapists may *not* be those with top-notch academic backgrounds. Psychotherapy is founded above all on *authenticity*, a quality which throws into question many of the ways society is currently organized. (Totton, 1992:27)

In our article “Whither the Human Potential Movement?” Juliana Brown and I argued that:

In our view, the current moves towards regulation and licensing derive from an implicit association with the medical model and with the medical professions as a model for professionalization. Members of the medical professions (as well as professions such as those cited by Courtenay Young - accountants, solicitors and

architects) are by and large persons who give advice or carry out actions on behalf of their clients. Their professional status assures the client of their authority and competence to act *without the client being fully involved* - not something we would hope is typical of humanistic practitioners! (Brown & Mowbray, 1990)²

These views reveal a crucial aspect of the ‘professionalization debate’: that different and conflicting aims are envisaged by activities that all refer to what they do as ‘psychotherapy’. For example, a perspective that envisages psychotherapy as a treatment and cure business focusing on the illness or problem to be alleviated (i.e. a ‘medical model’ activity) conflicts with a view of it as something primarily concerned with individual authenticity and uniqueness.

Whether or not one regards psychotherapy as a medical model activity in itself, the structures and procedures being established by UKCP do seem to me to be highly reminiscent of those of the medical profession. They do seem to me to be following the example of the medical profession as a model for professionalization as did the Foster and Sieghart reports that UKCP is heir to (see Chapter 5).

It is worth pointing out that there is in fact nothing legally dubious about the status of psychotherapy as things stand at present. The question of whether the creation of a statutory profession in this area would be a ‘good thing’ is of course a major concern of this book.

Protect the public from dangers and abuses

This is the standard justification put forward by professions seeking legal protection, and dangers and abuses are what seem to most preoccupy the media (a frequent lament is that ‘anybody’ can practise as a psychotherapist, which is true, but then would you go to just ‘anybody’?). ‘Safeguard the public’ is the standard stimulus for the standard reflex response ‘registration’. The Foster and Sieghart reports regard this as the primary objective of statutory control (see Chapter 5) and UKCP cites protection of the public as a main justification for its existence (see Chapter 6). However such justifications originating from within the humanistic psychology movement are noticeably infrequent.

*Some Stated Justifications for a Psychotherapy Register -
and Some Refutations*

What is usually absent from statements about this issue is evidence of the scale and severity of the risk to the public and of the reduction of risk that can be expected to ensue from statutory registration. Later chapters will explore these matters in depth.

Arguments for some form of psychotherapy registration as a necessary defensive strategy for practitioners are as follows:

Inevitability

An air of fatalism about statutory regulation has pervaded discussions amongst practitioners. It has often been talked about as though it was *inevitable*. What is an outcome desired by some has been assiduously ‘talked up’ as though it will be an inevitable achievement. Those who are unenthusiastic about the prospect of a statutory profession are counselled to go along with the process of its formation and thereby gain what little influence they can over it. From this stance there is little point in opposing it or questioning its wisdom.

Petrůska Clarkson assures us that whereas: “Previously, anybody could set up as a psychotherapist: that is, prior to the formation of UKCP... The voluntary Register which appeared in May 1993, will [*sic*] form the foundation of a Statutory Register of psychotherapists ...” (Clarkson, 1994:12).

Shirley Wade, writing about the involvement of humanistic psychology holds that: “We do not have the power to stop this tide of movement towards professionalism, and I see no fun in playing at being Canute ...” (Wade, 1990:53).

Courtenay Young proclaims forthrightly: “... Let me state it very clearly that psychotherapy (which includes psychoanalysis, humanistic psychology (as it is practised), clinical psychology, behavioural psychotherapy, NLP, family therapy, hypnotherapy and possibly psychodrama and many other psychotherapies) is almost certain to become more organised and regulated - *whether we like it or not*. This is a sign of the times. It is happening. There will be a register of accredited psychotherapists (almost certainly). This will have some form of government approval (eventually). It is becoming a (recognized) profession ...” (Young, 1991:54).

The Association of Humanistic Psychology Practitioners (AHPP) pro-

nounced confidently in 1991 that: "... The UK Government is expected to legislate in about four years time (1995) to protect either the title 'psychotherapist' or the title 'registered psychotherapist'" (AHPP, 1991a:37) and in 1992 Martin Jelfs, as chair of AHPP, extolled the latter's major influence on: "the inevitable and unstoppable professionalization of psychotherapy" (Jelfs, 1992a:17).

The assumption of 'inevitability' is heavily dependent upon the arguments that follow. As we shall see there is nothing inevitable about statutory professionalization.

Restrictions may be forthcoming from the government and it is better that we pre-empt them

Maybe, but it seems to be much more the case that far from providing a better alternative to less congenial legislative initiatives emanating from the government, UKCP is itself *a*, if not *the*, main source of pressure on a reluctant government.

In the course of compiling an issue of *Self and Society* on the topic of the registration of psychotherapists, the editor David Jones, having sounded out a "government source" on what the government had in mind for the registration of psychotherapists, concluded that: "I am not an experienced government-watcher and I make no claim as a prophet, but I would judge that the likelihood that government takes the initiative and introduces laws to change the basis on which psychotherapy is practised is about zero" (Jones, 1990:1).

According to Courtenay Young:

... the government have effectively said that they are not interested in legislation unless we (the UKSCP or the profession) want it.... (Young, 1990:5)

So, the government does not seem to be very interested in legislation - certainly not unless UKCP courts it, and UKCP *is* courting. UKCP representatives began to hold meetings with Members of Parliament and the Department of Health in 1990, launched its register in a room at the House of Lords in May 1993 and considered the need to hire a professional pub-

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lic relations officer to handle publicity: “in this crucial stage when we are working towards statutory registration” (UKCP, 1993i).

However the object of UKCP’s attention has yet to warm to the idea of a statutory register. Dr. Glenys Parry, from the Mental Health Policy Unit, Department of Health, implied that: “the possibility of a statutory register was not a ‘hot issue’ at the Department of Health, and was not likely to happen in the near future.” (*Self & Society*, 1994). The British Confederation of Psychotherapists states that: “we understand that the government has no intention of introducing statutory legislation in the foreseeable future” (Richards, 1994). Enquiries by ‘The Psychotherapy Centre’ have revealed that: “In the foreseeable future, according to the Department of Health, the idea of a statutory register of psychotherapists is a dead duck” (The Psychotherapy Centre, 1992). Finally, in his speech at the launch of the UKCP register, Tim Yeo, the then Parliamentary Under Secretary of State for Health, was explicit that: “the Government is most reluctant to contemplate legislation” (Yeo, 1993). This is a stance that has been consistently adopted by UK governments since the question of statutory control was first mooted by the Foster report in 1971.

Restrictions may be sponsored by other professional groups such as the medical profession or the academic and clinical psychologists. It’s better that we ‘get in on the act’ so that we don’t get left out.

This is always a risk. Laws in this area are nearly always initiated either by the occupation itself *or* by a rival group, as Hogan’s researches have revealed:

Licensure laws can be divided into two categories, depending on whether the law was initiated by the occupation or profession itself (“friendly” licensure) or by a group antagonistic to the group being licensed (“hostile” licensure)... Examples of the latter include many of the licensure laws applicable to the allied health professions.... Typically with hostile laws it is either a superior or rival professional group that initiates the law to curtail the development of the rival profession. This usually happens in an occupation that has hazy limits [such as psychotherapy] or which

overlaps with other related occupations [ditto].

In most cases, however, the profession itself is the one to seek legislation. Rarely if ever does a legislature license an occupation as a result of complaints raised by the public or specific consumers of the occupation's services.... Since few organized groups exist that might be opposed to licensing, it is not difficult for a profession to have itself licensed. Only when another professional group is threatened is there likely to be a legislative fight.... (Hogan, Vol. 1, 1979:243)

It has been argued that because UKCP includes representatives of the Royal College of Psychiatrists and the British Psychological Society, there is less risk of such bodies doing their own deal with the government with respect to psychotherapy (Young, 1990:8).

Maybe, but the government has not shown any interest in legislation (see above) and the psychiatric establishment was, it seems, opposed to the only actual legislative initiative to introduce statutory control of psychotherapy (Graham Bright's Private Member's Bill, 1981), since it feared that it: "would expose many of their members who were, alongside their NHS appointments, in private practice as psychotherapists without any proper training whatsoever" (Heron, 1990:18).

Furthermore, the government actually scuppered that bill by ensuring there was no time available for it to be taken up by parliament on account of there being: "too much dissension in the field to warrant statutory intervention" (ibid.).

Certainly, organizations such as the British Psychological Society and the British Association for Counselling have shown interest in some sort of statutory control, but the disparity of the field (amongst other things) has so far disinclined government to comply. It is UKCP's efforts to 'unify' the field that increase the chance of legislation.

The British Psychological Society (BPS) has been a Chartered Body since incorporation by Royal Charter in 1965, and has been authorised to maintain a Register of Chartered Psychologists since amendments to its Royal Charter in 1987. This also gave the Society a measure of title protection in the form of 'Chartered Psychologist' (BPS, 1993b). Because a Royal Charter is granted by Royal prerogative, the Society achieved this

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by Privy Council approval without legislation having to go through the House of Commons in the usual way. At its 1993 annual conference the BPS voted to pursue a statutory register of 'psychologists' and called for title protection of the term 'psychologist' (Hall, C., 1993; *Independent*, 1993). However, I do not believe that this could be achieved via the Royal Charter route.

From one perspective psychotherapy could be regarded as a form of 'psychological practice' and in some countries (e.g. Australia, Canada and the USA - see Chapters 8 and 12 and Appendices B and C) the practice of psychotherapy has been subjected to laws drafted to regulate the practice of psychology (though medical practitioners are usually exempt). This could conceivably happen here if BPS achieved its ambition to obtain title protection over the term 'psychologist', depending on how 'psychologist' was defined - if it was defined at all. It would be as well to be vigilant and to oppose any moves to allow such a licence, but one does not have to have a UKCP to prevent it happening.

European pressure

Developments in Europe, particularly the establishment of the European single market, have been cited as major justifications for the need for registration schemes here. These arguments deserve a chapter of their own.

Chapter 3

The European Bogeyman

1992 is the year of increased political union between the 12 [now 15] countries of the European Community. We can expect new laws to come into force within the next few years standardizing the regulations for psychotherapy in all member countries.

(David Boadella, 1991:33)

We feel that ‘1992 and all that’ has become the ‘bogeyman’ frightening this [human potential] movement into becoming a “profession” and “getting its house in order” whereas actually the main impetus seems to have been coming from a rather small nucleus of people within the movement (many with a vested interest in training) rather than from actual threats of regulation from outside. Ironically it may transpire that the resulting system of internal regulation will be what precipitates legislation by making it easy for government to legislate through the *apparently* representative bodies.

(Juliana Brown and Richard Mowbray, 1990:32)

During the run-up to the establishment of the European internal market in 1992, UKCP gained a higher profile as the issue of psychotherapy registration was discussed in terms of preparation for, or protection from, this closer union with Europe. Fears of the ‘coming European laws’ did much to boost support for UKCP from training organizations and practitioners.

It was argued that UKCP should be recognized as the only competent authority in the UK which can speak for all psychotherapists: “... hopefully thus preventing the atrocious oppression which has taken place in most countries of Europe, where only such psychotherapy as is approved and controlled by the psychiatric establishment is allowed to take place. Those countries where strict control is also exercised by the psychological establishment are regarded on the continent as liberal ...” (Rowan, 1991:33).

There are three related issues concerning the right to practise that are involved here: (a) the right of a national of another European Community/

Union¹ country to practise psychotherapy in the UK; (b) the right of UK nationals to practise psychotherapy in other European Community/Union countries; and (c) the right of a UK citizen to practise psychotherapy in the UK. Regarding rights (a) and (b), Courtenay Young has stated that:

... 1992 is the date that a free labour market is created in the European Community, which means that, if you are qualified or registered to work in one country, you have the right to work in any other EC country.... However, in practice this means that within psychotherapy, as no one is registered to work in this country, no-one in Britain can claim this right, but all the Dutch psychologists and psychiatrists can claim the right to work in Britain - where there aren't any restrictions anyway. So, behind the initial sighs of relief, there is quite considerable pressure to form a register of psychotherapists.... those people on the register will be able to identify themselves in some way and can thus claim the right - in stropky countries like Holland and Spain - to work as a registered psychotherapist. (Young, 1990:5-6)

A statutory register in the UK would restrict other European Community/Union nationals in the same way as UK citizens and thus presumably stem any 'flood' of would-be but 'unqualified' continental psychotherapists heading for Britain and taking work from us 'Brits'. However, statutory registration in the UK would not affect the right of UK citizens to practise in another Member State *unless* that country also has such official recognition of a profession of psychotherapy.

As of February 1995, it appears that Member States which have statutory recognition of psychotherapy as a distinct profession are in a minority (see Chapter 8). Arguments for a statutory register in the UK that concern rights (a) and (b) are not very strong unless you are keen to practise in one of these countries (such as Italy or Austria) or are eager to prevent the residents of other Member States from practising here.

Most fear has, I think, been generated by the spectre of changes in the European Community/Union affecting (c), the right of a British national to practise psychotherapy *in Britain*. However, developments regarding the European internal market do not affect this right:

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... The EEC Directive [The Mutual Recognition Directive 89/48EEC], to be implemented in 1991, not 1992, will not affect the right of complementary and alternative practitioners to practise privately under common law in the country....

The Directive contains nothing specific to individual professions or occupations. It will not affect existing systems of internal regulation and the text of the Directive makes this clear. In the UK therefore, where there is no registration or qualification required in order to practise, the Directive makes no difference to the existing pattern of alternative therapy practice. Similarly, nationals of other Member States will be free to practise in the UK on the same terms. Where other Member States prevent alternative professions from practising or require supervision by medically trained practitioners this too will remain unchanged. ('A Government Source', 1990:3)

In 1990 David Jones informed us that: "And what, I hear you ask, has the EEC and 1992 (well 1991 actually) got to do with this? The EEC has no plans to legislate for psychotherapy so the answer is it provides an occasion not a cause for people to see if their house is in order" (Jones, 1990:2).

However in 1991 he reported that: "The Dutch government, prompted by its professionalized psychotherapists, are taking the lead in proposing that EC countries register psychotherapists and that it be a profession limited to those at postgraduate level. The British government looked into this and consulted the established bodies in the mental health area such as the British Psychological Society, social work organizations, psychiatrists etc. - about two dozen bodies altogether. They wanted a view of, among other things, the standing of the United Kingdom Standing Conference on Psychotherapy (UKSCP which emerged from the Rugby conference). Government seems to be persuaded that UKSCP is competent but comprehension seems to be seriously hindered by the assumption on government's part of a medical model of treatment" (Jones, 1991a:51). Moreover: "... The Department of Health is centrally concerned with this issue although in some ways the Department of Trade and Industry is more involved with the actual regulations. Both departments, indeed the whole

civil service, assume that psychotherapy means either psychiatry or psychoanalysis ..." (ibid.).

In June 1991, David Boadella, referring to: "the coming Euro-laws", maintained that: "There exists a professional watchdog of the EEC called SETLIP. It has the power to issue sectoral directives regulating the practice of psychotherapy. These are compulsory restrictions binding on all member countries. SETLIP can be asked to issue such a sectoral directive when the professional associations of any seven member countries unite to ask for this. At the moment [June 1991], the Dutch Psychology Association (NVP) has begun a process of contacting six other national psychology associations in Europe to request SETLIP to issue a sectoral directive ordering that the title 'psychotherapist' could be legally used only by doctors and psychologists ..." (Boadella, 1991:33). He went on to present UKSCP as a bulwark against the threats posed by SETLIP, the EEC, and the: "faceless men of Brussels" and as an organization seeking to: "directly protect the rights and freedoms of both responsible therapists and of the public" (ibid.: 34).

When I made enquiries about SETLIP with the London Information Unit of the European Commission and the pertinent department in Brussels neither had ever heard of any such organization and I was told that the above description of the powers attributed to SETLIP (whatever that organization is, perhaps SEPLIS?²) was: "completely false". Only the Commission itself has the power to issue sectoral directives (under very restricted circumstances) and it has abandoned the policy of doing so in favour of Directive 89/48/EEC (see below). If all this leaves you uncertain as to whether SETLIP actually exists, well so am I.

The European legislation applicable in this area is to be found in Articles 48-58 of the Treaty of Rome which provide for the free circulation of wage earners and allow others to work in another Member State, either permanently (right of establishment) or by supplying services across frontiers, along with the directives that derive therefrom.³ These provisions were intended to foster economic integration by creating a "common market in manpower" on the basis of non-discrimination on the ground of nationality (Cuthbert, 1994:70).

In 1987 the Single European Act came into force, supplementing the Treaty. It gave the Community the means to establish, by the end of 1992,

a large European internal market - an area with no frontiers between the Member States. To that end, barriers to the free movement of persons, goods, services and capital needed to be eliminated. Among those barriers are differing conditions for the exercising of many professions. These conditions infringe upon the right under the Treaty itself for the self-employed to establish themselves in any member country, under the same conditions pertaining to nationals of the host country (*European File*, 1989).⁴

The response of the Community to this problem of differing requirements between Member States was the adoption of various specific or 'sectoral' directives applied to particular professions starting in 1976 with medical practitioners. These directives were based on a process of harmonizing the conditions under which professions could be exercised and particularly, coordination of training (*ibid.*). However, this process was found to be so difficult and slow, because of the need for consensus between all Member States, that from 1985 it was abandoned in favour of a broader approach in line with the subsidiarity principle of the Maastricht Treaty⁵ (European Commission, DG 15/E/2, 1995). This new approach is based on a general system for the mutual recognition of diplomas incorporated in the Mutual Recognition Directive 89/48/EEC. This states the basic rule that Member States who themselves require a 'diploma' as a condition of practising a *regulated profession* must accept a 'diploma' issued in another Member State, provided it conforms to the following conditions:

It must be awarded by a competent authority in a Member State (i.e. one designated in accordance with its own laws or regulations) after successful completion of a course lasting at least three years at a university or similar establishment and of professional training required in addition where appropriate. The diploma must fulfil the professional qualifications required for the taking up or pursuit of a *regulated profession* in that Member State. Qualifications obtained via non-standard routes (e.g. part-time study or correspondence courses) are also covered, provided they are equivalent to those obtained by the conventional route *and* give the same rights of access to the profession in that state (*Official Journal of the European Communities*, 1989).

A professional activity is "regulated" in the sense of the Directive if its pursuit is restricted to the holders of a "diploma". The

Directive gives two particular examples of “regulation”: Regulation by means of protection of title, i.e. by restricting the use of a professional title to persons with a with a particular diploma, and regulation by virtue of the fact that social security arrangements only allow the remuneration of professionals holding a diploma (often the case with professions in the health field). (Commission of the European Communities document, 3.90)⁶

In a telephone conversation, the head of the European Commission department concerned with the recognition of professional qualifications emphasized that the Commission is *only* concerned with facilitating migration *between* Member States. The Commission is *only* concerned with the mutual recognition of diplomas between Member States *in which a profession is already regulated*. The Commission is not involved with altering the situation *within* a Member State such as with promoting the registration of a profession in a particular Member State where it is not already subject to statutory regulation (European Commission, DG 15/E/2, 1993).

So, the Commission is not seeking to harmonize the regulation or training of *any* profession. Regarding ‘psychotherapy’ in particular, the term is regarded as vague and the Commission is aware that this activity is quite different between Member States - in some it is a regulated profession, in some it is not and in some it is difficult to distinguish psychotherapists from psychologists (European Commission, DG 15/E/2, 1995). “The possibility to have an evolution [in this profession] is quite little, quite small” (ibid.).⁷

The Commission still has the power to pursue a specific, sectoral directive for psychotherapy, but this would involve a reversal of policy by the Commission and in any case such a specific directive would only be possible if the following three conditions were met: (1) there is a consensus amongst Member States; (2) there is a consensus amongst all the organizations that represent the profession and (3) the Commission thinks that a such a directive is needed to improve the free movement of members of the profession (ibid.). So, the possibility is indeed “quite small”.

To summarize, the position in the European Community/Union regarding the regulation of psychotherapy (as of February 1995) is that *there*

is no pressure from the Community institutions to introduce statutory regulation of psychotherapy in Member States: “The Commission does not plan to make specific proposals for psychotherapists regarding their activities in general or their access to social security systems in particular” (European Parliament, 1993:2).

The more I have looked into this matter, the less has it seemed the case that the much vaunted ‘pressure from Europe’ has been anything to do with the Community/Union institutions or has really been something that would affect the right to practise psychotherapy *in the UK*. This view is confirmed by the British Confederation of Psychotherapists: “... It seems very unlikely that this government will introduce statutory legislation at any stage in its lifetime or that standards will be imposed from Europe” (BCP, 1994). It seems more likely that the supposed ‘European pressure’ has been a stalking horse for pressure from interested parties within the UK in cahoots with interested parties in other European countries. Certainly ‘1992’ proved to be a non-event in this regard. There seems to have been a great deal of misinformation put about and reliable information has been hard to come by. Whatever pressure there has been from outside the UK seems to have had its source in continental professional groups rather than The European Community/Union institutions as such.

Increasingly this appears to me to be a classic case of a purported ‘external threat’ used to bolster domestic political objectives by harnessing the fear so engendered. If everyone is led to believe that ‘Euro laws’ requiring regulation of psychotherapy are inevitably coming our way, it becomes easier to invent the domestic version.⁸

The conclusion that there is no impending European regulation of psychotherapy was confirmed in June 1994 by Dr. Alfred Pritz, Chief Executive of the European Association for Psychotherapy (EAP)⁹ who, in his address to the EAP sponsored conference ‘A Peaceful Revolution for Health Care in Europe’, described the future of psychotherapy in Europe as being not about one regulation for all countries but rather about recognition of quality standards between various countries (Collis, 1994b:2).

Even if the threat of pan-European regulation were to prove real and substantial, a UKCP register is not the only response that could be made. The arguments in this book are very much concerned with the drawbacks of conventional systems of professional regulation and the barriers to en-

try to an area of economic activity that they represent. I favour the deregulation of professions except where a really solid case can be made for the protectionism their establishment represents. The principles behind these arguments are therefore quite compatible with the principles of an open market that lie behind the European legislation - although applied from a different perspective. Removing unnecessary barriers to entry to occupations would actually foster the European internal market if it were done on a Community wide basis.¹⁰

There are in fact trends in Europe moving in favour of deregulation and the elimination of restrictive practices. For example Roland Berger, German management 'guru', has described Germany's service sector as suffering from excessive protection and regulation which has inhibited its efficiency and growth (Eisenhammer, 1993) and in Britain the monopolies of traditional professions have come under attack from government.

Furthermore, the legal situation for the field of psychotherapy in Germany has undergone a dramatic liberalization as a consequence of a court case in January 1993 (Bundesverwaltungsgericht, 1993). This case challenged some of the previous requirements of the 'heilpraktiker' system on the grounds that they were in contravention of free market legislation, since they were irrelevant to the practice of psychotherapy. The resulting judgement found that the freedom to exercise a profession had been unacceptably restricted. According to Silke Ziehl (1994a), as a consequence, there has been an enormous loosening of the system of regulation, allowing for a much broader access to the occupation.¹¹

Given a greater understanding of the issues involved, the UK government, favouring deregulation as it does, might be encouraged to support these trends, to lobby for more deregulation in this field in the rest of the Europe and to resist any pressure to go over to a *more* regulated way of doing things here. The government obviously has no idea what growth models and humanistic psychology are all about (Jones, 1991a:51), perhaps through having taken its counsel largely from the medical profession and psychoanalytic lobbies in the past. The government could be educated more about the variety in the field of 'psychotherapy' and the lack of basic agreement as to models, goals and means - revealing the 'disorder' - rather than hiding this under the cloak of an apparently representative body which invites, nay yearns for, legislation and makes it easier to enact.¹²

Chapter 4

The Hidden Agenda of Professions

It is my opinion that the professional's role in a free society should be limited to contributing technical information men need to make their own decisions on the basis of their own values. When he pre-empted the authority to direct, even constrain men's decisions on the basis of his own values, the professional is no longer an expert but rather a member of a new privileged class disguised as expert.

(Eliot Freidson, 1972:382)

... vested interests masquerading as the public interest...

(Kenneth D. Benne, 1979)

... [Dr. Sandy Macara, chairman of the British Medical Association (BMA)] is also part of what, until recently, was the most successful interest group in politics. Dr. Macara, after all, is nothing more than a trade union leader, defending, with a revenue of £40m a year, the interests of 90,000 highly-paid workers. Other unions have tried to give the appearance of transcending sectional interest ... but only the BMA really brings it off. "Patients will suffer unless doctors get more" is the medical correspondent's joke....

(Jack O'Sullivan, 1994)

Why should a 'profession' be regarded differently from other occupational groups and allowed special privileges, such as protected titles and practices and yet be exempt from the application of monopoly laws and, more often than not, retain effective control of the systems intended to regulate it? It is clearly not just a question of doing a 'professional' job of something as this description could be applied to any occupation. As discussed in Chapter 2, professions tend to occupy an 'agency' role, doing things for

their clients on the basis of an elaborated body of knowledge that their clients would not have the time, capacity or inclination to master. However the same might also be said of an electrician or plumber.¹ The professional's knowledge base tends to be highly theoretical and academic and access to it is usually on the basis of a university degree. Professions with a less academic background tend to have a lower status - and income potential - and may be supplementary to, or under the aegis of, another profession as for example nursing is to medicine. The increased lifetime's earning capacity that often results from becoming a member of a recognized profession is usually far in excess of the cost of the education and training involved, notwithstanding that the cost of such training is likely to be directly or indirectly subsidized by government. There are also overtones of social class about professions. Professions such as medicine or the law have come to occupy the upper reaches of the occupational class system in terms of perceived status.

It is usually supposed that one of the distinguishing features of the professions is that, compared with other occupations, their members are motivated less by profit-maximization and more by altruistic considerations of public welfare as evidenced by their codes of professional ethics. For this reason, amongst others, professions tend to have high prestige. However Talcott Parsons (1968) argues that it is more in keeping with the facts that the professional has much the same motivation as the business person. In addition to whatever altruism there may be (a human trait not confined to the professions), there is also a more self-serving side to professions. Slovenko maintains that:

According to theory, in return for a monopolistic right of practice, there is a reciprocal commitment to admit only individuals of proven competence, to insist on the observance of an ethical code of conduct, and to protect the public against bungling and extortion. In virtually every profession, however, disciplinary enforcement is virtually nonexistent. The little enforcement that is applied, does not act as a deterrent and is often done to protect the reputation or economic interest of the group rather than protect the public from harm. (Slovenko, 1979)

Take the case of the medical profession for example, which is often supposed to be amongst the most altruistic of professions. The British regulatory authority for the medical profession, the General Medical Council, was given its monopoly over the medical register when it was set up in the nineteenth century. Meg Stacey, Emeritus Professor of Sociology at Warwick University served as a lay member on the General Medical Council in the eighties and has made it the subject of detailed research. Commenting on the establishment and operation of the Council, she said that: “They really made a pact with the state to say we will regulate ourselves so that patients who come to us can trust us to treat them in a proper manner. We’ll do that, if you give us certain privileges ...” (BBC Radio 4, 1994b). However she had to conclude that in practice: “... the pressures from the profession always made them [the members of the Council] lean somewhat to the profession rather than to the public” (ibid.). (For more on the General Medical Council see Chapter 9.) One view on the BMA has been quoted at the beginning of this chapter. Rayack’s study of the American Medical Association (AMA) came to the conclusion that:

Our analysis of the policies and practices of the American Medical Association since the turn of the century demonstrates beyond question that the critics of the AMA are fundamentally correct.... Society has delegated considerable power to organized medicine, and the AMA and its constituent societies have all too frequently used that power in a socially undesirable manner. Furthermore, our brief look into prospective developments in the medical market indicates that organized medicine will often be in the position where it can continue to use its power to protect the economic interests of its members at a very real cost to society. (Rayack, 1967:287)

More recently, the US medical/pharmaceutical/health insurance lobby has been described as the most powerful lobby group in the world and one that has waged virulent campaigns against any other systems that could be held up as better and cheaper alternatives (such as the UK’s NHS or the Canadian health care system): “Anything that comes forward as a plausible alternative will be subject to violent attack” (BBC Radio 4, 1993a).

So, however altruistic the individual medical practitioner may be, it would seem that on the collective level medical practitioners cannot be relied upon to act any more altruistically than your average corporation.²

According to the analysis of Lippitt and his associates, historically, professions have had:

... a tendency to confuse credentials with competence. They have tended to define credentials more and more in terms of external badges of schooling and degrees, which are only obtainable through a rigid educational route. They have acted at times solely to protect the vested economic interests of their members, including resisting expansion of membership. Professions have also tended to resist the development and use of paraprofessionals [and self-help], and have been tardy in recruiting and training volunteers. They have tended to cultivate in the public the myth that the profession is all-knowing and all-powerful, rather than educating the public as to the profession's strengths and weaknesses. Finally, the professions have tended to coalesce with and be responsive to established institutions, rather than those lacking power. (Lippitt et al., 1975)

Defining a 'profession' is problematic. Goode concluded that the two most important characteristics cited in common definitions of a 'profession' are a : "prolonged specialized training in a body of abstract knowledge, and a collectivity or service orientation" (Goode 1960:903). In addition, Goode argues that as occupations become more professionalized they tend to possess more and more of the following highly specific traits:

1. The profession determines its own standards of education and training.
2. The student professional goes through a more far-reaching adult socialization experience than the learner in other occupations.
3. Professional practice is often legally recognized by some form of licensure.

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4. Licensing and admission boards are made up of members of the profession.
5. Most legislation concerned with the profession is shaped by the profession.
6. The occupation gains in income, power, and prestige ranking, and can demand higher calibre students.
7. The practitioner is relatively free of lay evaluation and control.
8. The norms of practice enforced by the profession are more stringent than legal controls.
9. Members are more strongly identified and affiliated with the profession than are members of other occupations with theirs.
10. The profession is more likely to be a terminal occupation. Members do not care to leave it, and a higher proportion assert that if they had to do it over again, they would again choose that type of work. (ibid.)

Some who support the establishment of psychotherapy as a profession actively encourage the ‘socialization process’ referred to above:

Professional training, if it truly succeeds, leads to a psychological amalgamation of the person with the function that he is to perform. We speak then not of having a job, but of being a member of a profession. Professional people are strongly identified with what they do, they derive pleasure and pride from the status which their function affords them in their community, and they find it difficult to think in terms of change even if greater economic security is offered, because their deepest satisfactions stem from carrying on their profession which has become part of their life. This sense of professional identity is an essential attribute in a profession such as psychotherapy, and its acquisition must be considered as one of the important training goals. (Ekstein & Wallerstein, 1958:66)

Responding to this, Masson tersely concludes that: “In short, one is learning to become a loyal member of a select group” (Masson, 1988:294). In

fact the term 'profession' derives from the vow taken by novitiates entering a religious order (Holmes & Lindley, 1989:209).

The adoption of a specialist language that is both a vehicle for the profession's particular area of knowledge and a means whereby that knowledge remains less accessible to lay understanding is often part of this 'socialization process'.

The rise of the professional model as a form of social organization in this century has been compared by many political scientists to a return to the guild society of the Middle Ages (e.g. Lieberman, 1970). This has occurred in parallel with a shift from capital to knowledge as a basis for power in society. Hogan outlines the nature of the guilds as follows:

The basic element of the early guilds consisted first and foremost of the requirement of compulsory membership. This ensured that all practitioners would be subject to the guild's mandate and effectively established a monopoly.... The guilds fit perfectly into medieval conceptions of society, which included a belief in a hierarchical organization of authority, *the importance of status versus contract*, and a fusion of governmental authority with non-governmental bodies. (Hogan, Vol. 1, 1979:223-224)

The guilds had a debilitating effect on economic growth through their monopoly power and through the irrelevant membership requirements that maintained it. When they eventually disintegrated - most of them shortly after the fifteenth century - this was considered a:

Welcome release from what had become an unreasonable interference with the free play of economic forces, and their demise generally is accounted one of the principal elements in our vaunted advance from 'status' to 'contract'. (Grant, 1942:303)

Professions seek a monopoly over an area of economic activity supposedly to protect the public from incompetent practitioners ('non-malfeasance'), but they have in practice tended to become perpetually over-concerned with the establishment of, the protection of, and the enhancement of their own social status and economic position. In view of

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this well documented hidden agenda, the statements of professional bodies should not be taken on trust but rather regarded with appropriate circumspection. Sound evidence should be demanded to justify any legal restrictions in their favour. Such evidence is sadly lacking in the Foster and Sieghart reports that set the psychotherapy registration ball rolling in the UK and to which I now turn.

Chapter 5

Precursors of the Current Proposals for the Statutory Registration of Psychotherapy in the UK

Scientology did not become a matter of major concern for the Press again until the summer of 1966, when one of the national daily newspapers reported extensively on “The Case of the Processed Woman”.

(Foster, 1971:1)

... When Scientology was investigated (Foster, 1971), their practices of ‘auditing’ and ‘processing’ were seen to be so dangerous that statutory regulation of psychotherapy was called for...

(Mark Aveline [UKCP Board member 1993], 1990:325)

Following twelve years of deliberations, UKCP is now launching a national register of psychotherapists, as recommended by the Sieghart Report of 1978.

(UKCP, 1993b)

UKCP presents itself as the natural outcome of the Foster and Sieghart Reports and refers back to them for validity. A look at what these weighty sounding reports actually are and the context of their production is instructive since the case for statutory control is in part based a presumption of the soundness of their conclusions. Despite their relevance to the current debate, the Foster Report is out of print and the Sieghart Report is difficult to get hold of.

The ‘Foster Report’ (Foster, 1971) was produced by Sir John Foster KBE, QC, MP as the outcome of his inquiry into Scientology which was instigated by the government in response to: “public outcry about the ‘ab-

duction and corruption' of vulnerable young people by L. Ron Hubbard's Church of Scientology" (Holmes & Lindley, 1989:209). Margaret Percy gives a different slant on the background: "... the British popular press began a witch hunt of Scientologists and their founder and by 1968, in an extraordinarily uncharacteristic move, the government slapped an Aliens Order on Scientology, a ban which was only lifted three years later ..." (Percy, 1987).

The Sci-fi jargon and computer-speak such as 'Preclear', 'Thetan', 'Engram', and 'Processing' that is endemic in Scientology must indeed have sounded very strange as readers perused their *News of the World* on a Sunday morning. One could forgive them for concluding that 'aliens' had indeed landed!

Foster did in fact condemn the government's use of an Aliens Order as "wrong in principle" on the grounds that it was discriminatory to exclude foreign nationals simply because they were Scientologists, when there was no legal impediment to the practice of Scientology by UK citizens, and all the more so, when there was no right of appeal against an 'Aliens Order' as was the case at the time (Foster, 1971:158).

The Foster Report comprises 193 pages, most of which is taken up with extracts from Scientology publications and documents. Foster's inquiry was held "in private" and he did not hear any witnesses or advocates: "... In consequence, I have treated myself as being disabled from passing any adverse or favourable judgement of Scientology, its practitioners or practices ..." (ibid.:v). Nor did Foster seek any direct evidence or testimonials as to the harm or otherwise that Scientology might be causing in the UK. As "background", he cites reports from elsewhere, notably Australia, where a similar story concerning reactions to Scientology underlies the history of Australian psychology legislation (see Appendix B).

In 1963 a Board of Inquiry was set up in the state of Victoria under the leadership of Mr. Kevin Victor Anderson QC and produced a "wholly unfavourable" report on Scientology in 1965 - six years before Foster (ibid.:5). This 'Anderson Report' came to the lurid conclusion that:

Scientology is evil; its techniques evil; its practice a serious threat to the community, medically, morally, socially; and its adherents sadly deluded and often mentally ill. (Anderson Report, 1965:1)

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Note the blanket condemnation. In fact the Anderson Report also states that: “The Board has been unable to find any worthwhile redeeming feature in Scientology” (ibid.:2).

More soberly, in 1970 the Report of the Committee on the Healing Arts in Ontario, Canada concluded:

We had already adopted the position ... that there was a point beyond which we would not go in restricting the rights of mentally competent individuals to seek treatment from health practitioners of their own choice, unless we found evidence that the practice might be harmful.... We did not believe that the compilation of further evidence pertaining to Scientology would be likely to cause us to recommend the prohibition of its practice in Ontario.... (Quoted in Foster, 1971:11)

Amongst the features of Scientology which gave rise to public anxiety in various countries at the time were promotional and recruitment methods that would put some double-glazing firms in the shade. As Foster said: “Some people may also find it novel to discover a religion which recruits new members by the methods of salesmanship and a ‘free personality test’ ...” (Foster, 1971:58). Moreover this was a church that offered processing and training courses for considerable fees. The notorious ‘free personality tests’ were studied by a working party of the British Psychological Society who concluded that there was: “an extremely strong case for assuming it to be a device of no worth” and that: “The prime aim of the procedure seems to be to convince ... people of their need for the corrective courses run by the Scientology organization” (ibid.:76-7). However, apparently there are now doubts about the validity of *any* personality tests. Occupational psychologist Steve Blinkhorn for example regards personality testing as: “inaccurate 90 to 99 per cent of the time”, a view which is attracting growing support (Palmer, 1994).

Also giving rise to public concern were those Scientology activities that were held responsible for contributing to family estrangements. The practice of ‘disconnection’ involved inducing trainee Scientologists to disconnect from close relatives who were considered to be acting as ‘Suppressive Persons’. This activity was part of Scientology’s strict disciplinary

arrangements which were administered by an executive agency call 'Ethics' that operated by holding 'Ethics Courts' with the sanction of the assignment of a 'Lower Condition' on the accused - including a 'Suppressive Person' order. There was also concern about the 'auditing' of minors albeit with their parents' consent and about the pressurizing of former members of the organization. The above might be described as amongst the more 'cultish' aspects of the organization.

Of more immediate concern to the subject of this book are the Scientists' 'processing' or 'auditing' techniques which Foster regarded as the principal practice of Scientology and which he concluded constituted the practice of a form of psychotherapy, a view which Hubbard himself had shared at one stage. In fact, Foster concluded, largely on the basis of their own literature, that the Scientists were practising both psychology - the offering of 'personality tests', and psychotherapy - the 'processing' or 'auditing' procedures (Foster, 1971:176).

Foster showed distinct signs of an allegiance to the medical model in this area and referred to psychotherapy as "psychological medicine":

... Psychiatrists [*sic*] broadly speaking, practise two distinct kinds of therapy: 'physical' medicine, which seeks to affect our minds through our bodies by material interventions such as electric shocks or drugs; and 'psychological' medicine, which seeks to affect our minds directly and without any material intervention. For this last technique I propose to use the expression 'psychotherapy' regardless of the particular school or discipline - such as 'psychoanalysis' or 'analytical psychology' - which the therapist happens to follow.... (Foster, 1971:176)

Foster went on to conclude that there was a strong case for legislation to control the practice of psychotherapy or 'psychological medicine' in the UK:

... psychotherapy (in the general sense of the treatment, for fee or reward, of illnesses, complaints or problems by psychological means) should be organized as a restricted profession open only to those who undergo an appropriate training and are will-

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ing to adhere to a proper code of ethics, and that the necessary legislation should be drafted and presented to parliament as soon as possible. (Foster, 1971:v)

Given that Foster, because of the form and scope of his inquiry, did not see himself as being in a position to judge the practices of Scientology, whether of psychotherapy or otherwise, it is hard to see how he arrived at this conclusion on the basis of the content in the body of his report. The report is largely uncluttered by any supporting evidence regarding such things as the scale of problems concerning the unregulated practice of psychotherapy in the UK (by Scientologists or anyone else) or the efficacy of statutory regulation as a solution.

In fact Foster cites only one particular example of where harm was supposed to have resulted from the application of Scientology ‘processing’ techniques as such and that was in Australia. This concerned a person whose ‘auditing’ session actually formed the basis of a demonstration for the Anderson Board, who reported on it as follows:

The particular session demonstrated what was called ‘listen style auditing’. It was said that this was one of the simpler processes, quite a low grade process, and was designed to help people to talk about their worries and problems and get them ‘off their chests’, on the basis that people found relief when there was someone ready and willing to listen to them. It enabled the person with problems and worries to talk about them and the ‘auditor’ [i.e. the practitioner], on this occasion being very literally one who listened, merely started the ‘preclear’ [i.e. the client] talking and then sat silent, providing a receptive ear.

The demonstration session was of about thirty minutes duration....

... Nine days [*sic*] after the demonstration session this ‘preclear’ was admitted as a patient to the care of the Mental Health Authority.

The Board is appalled at the realization that it witnessed this unfortunate woman being processed into insanity. At that early stage of the Inquiry the Board had not been informed of the

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potentially dangerous nature of this apparently simple and easy 'listen style auditing'. Subsequently a psychiatrist witness who read the transcript of this woman's demonstration session gave evidence that her behaviour in the session indicated clearly that she was in a state of mania rather than ecstasy, which would have been readily apparent to a psychiatrist [Is an exploration of ecstasy part of a psychiatrist's training?]....

The kind of treatment given to this unfortunate woman was the very kind which precipitated her breakdown. The Board heard expert psychiatric evidence to the effect that it was one of the well known traps in handling depressives to believe that by encouraging them to talk and 'get things off their chest' one was doing some good. In dealing with a person showing signs of depression, psychiatrists have to exercise great care and judgement in determining whether it is advisable to allow the person to talk about himself or not.... In order to determine whether a patient should be allowed to talk about himself, the psychiatrist must be a highly trained physician, with insight of many branches of medicine....

There was further expert psychiatric evidence that such techniques as 'listen style auditing' encourage a trust and dependency by the patient on the 'auditor', and tend to mobilize guilt and bring up emotions and anxiety in the 'preclear'. Such anxiety tends to provoke more symptoms, more anxiety and perhaps more depression, leading to a worse situation.... (Anderson Report, 1965:134-5)

The response of the Scientology organization to the above account from the Anderson Report is of interest:

Out of thousands of persons who had been helped by increasing their knowledge about themselves and life generally, Anderson could only find one person whom he could allege had been harmed by Scientology. He deals with her case at length in the Report. Even then he was way off!

He announces to the world that one woman was processed

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into mental derangement in his presence. He does not state that he knew that this person had a long history of mental illness; she had been in and out of psychiatric wards.... Her husband and relatives were violently against Scientology. After she went home [from the demonstration], she had a very troubled time from some members of her family. Her husband threatened her and continuously insulted her and threatened to injure her daughter. This caused a heavy strain. Her grandmother told her all the time how bad she was; she had no one to turn to. The doctors were against Scientology, which, at that time, was under heavy governmental attack. Thus nine weeks [*sic*] later, in order to get away from these persons who were literally driving her mad, she signed in as a voluntary patient in one of Dr. Cunningham Dax's institutions. Anderson was so delighted about this case, that he refused to hear any evidence of the contributory causes of this woman's relapse.... (Church of Scientology, 1967:23)

Such 'evidence' of harm as this is hardly a sound basis for a proposal for statutory regulation. So how did Foster arrive at the apparent *non sequitur* of his recommendations?

A partial explanation is offered by Foster thus: "That it is the phenomenon of Scientology which has pointed out this need in the existing law is a matter on which, if it is the leadership's sincere desire to help humanity, they will have cause to congratulate themselves. Without coming to any conclusion on whether they in fact exploit their followers for their own profit, or whether it is desirable for auditors who may have had only a few weeks training since they came to Scientology with problems of their own, to be encouraged to practise psychotherapeutic techniques on those who, *ex hypothesi*, are sitting targets for exploitation, the mere fact that such a situation could easily be abused at the present time with impunity demonstrates the urgent need for reform" (Foster, 1971:179-180). Thus, being careful not to actually judge the practices of Scientology because he regarded himself as being disabled from doing so by the nature of his inquiry, Foster nevertheless makes clear his opinion of those practices and in effect says there isn't a law, there could be abuse, therefore there should be a law as there is elsewhere.

Looking a bit deeper, it seems that Foster: "... knew very little about psychotherapy, and therefore took advice from the psychoanalytic lobby. Following this advice, he condemned the Scientologists on the grounds that they were exploiting emotionally vulnerable people *and abusing the dynamics of the transference*. And he recommended the statutory registration of psychotherapists in private practice in order to protect the public from this kind of abuse" (Heron, 1990:17). This makes sense of the analytic bias in his final chapter where he makes his recommendations. For example he refers to the 'transference effect' as the: "principle technique in the armoury of modern psychological medicine" (Foster, 1971:177).

Foster explicitly cited established professions such as lawyers, doctors, architects and nurses as analogies for the statutory profession he proposed: "all put at their clients service, for reward, intricate skills of which the clients are ignorant and which they must largely take on trust" and showed enthusiasm for: "the traditional method ... to protect the weak from the exploitation which such a dependence makes possible ... [the creation of] a controlled 'profession' ... [which has] worked excellently in the past ..." (ibid.:178).

Foster's enthusiasm for statutory professionalization as a form of social regulation should not be particularly surprising given the era in which he was writing and that he was himself an eminent member of the legal profession, a profession whose own restrictive practices had yet to come under much in the way of public scrutiny.

Foster's recommendation that psychotherapy should be regulated by statute received the support of the British Medical Association and the Royal College of Psychiatrists.

In 1974 the British Psycho-Analytical Society initiated a meeting between the Department of Health and Social Security and itself, along with six other practitioner organizations, in order to discuss the recommendations of the Foster Report. In response to this meeting the DHSS indicated in a letter dated 22 January 1975 that: "it could not hold out any hope of any government legislation in the foreseeable future" (Sieghart, 1978:1). The DHSS suggested that the organizations present might like to establish a joint working party to develop their proposals in more detail - hence the 'Sieghart Report': "Statutory Registration of Psychotherapists: The Report of a Profession's Joint Working Party." Chairman Paul Sieghart, 1978.

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The Sieghart Report is an altogether much slimmer work than Foster's, consisting of a pamphlet of about 40 pages (10 of them devoted to extracts from Foster's report). The Sieghart Report introduced the terms 'Functional Registration' (practice act) and 'Indicative Registration' (title act) and favoured the latter for psychotherapy registration on the grounds that there was no way of defining the practice of psychotherapy with enough certainty to allow a court to decide whether someone was practising it or not. Titles to be protected were 'psychotherapist', 'psycho-analyst' and similar titles, "together with (as is customary in such cases) any other description which might lead people to believe that the user was on the statutory register" (Sieghart, 1978:vii).

Foster had not been specific about which type of registration he proposed but he appeared to have in mind a practice act (ibid.:6).

Sieghart proposed the setting up of a Psychotherapy Council and: "... As in the case of other professions, the Council must therefore be composed of experienced and responsible members of the profession which it will regulate..." (ibid.:ix).

This turns out to be largely nominees of the bodies who constituted the working party along with a few elected places for registered psychotherapists not already represented by those bodies and a "lay" membership of approximately a quarter of the Council. "Lay" here means people who are not themselves psychotherapists. What they had in mind were doctors, lawyers, nurses, social workers etc. and: "... Ideally, there should be someone who can represent the interests of the profession's patients, but we have not been able to suggest how such a representative could easily be identified" (ibid.:x).

Like the Foster Report, the Sieghart Report leans heavily towards the medical model and the profession of medicine as the model for a profession of psychotherapy and refers to 'psychotherapy' as: "this field of medicine" (ibid.:1).

Like the Foster report, the Sieghart report has great faith in the: "well tried method of creating a statutory register of practitioners" as the best way to protect the public (ibid.:5).

A 'grandfather clause' was recommended as is common in these cases of profession formation, not least because it forestalls possible opposition from already established members of the occupation.

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The Sieghart Report does not cite much in the way of empirical evidence to support its recommendations and largely relies on Foster for this who, as we have seen, does not cite much evidence either. However, it does cite a memorandum submitted by the Royal College of Psychiatrists in response to a request from the DHSS for comments on the recommendations of the Foster Report for legislation to control psychotherapy. This memorandum claimed that:

There is ample clinical evidence that psychological procedures can cause harm if carried out by unqualified practitioners. The very procedures of psychotherapy which in competent hands can produce major beneficial effects are more likely in unqualified hands to have harmful effects.... The danger of harm would be reduced if there were sufficient statutory control.... (Royal College of Psychiatrists, 1972)

Sieghart also cites with approval a similar memorandum by the British Medical Association and concludes: “We have no hesitation in subscribing to all these views. We agree with Sir John Foster’s conclusion that there is a strong case for legislation in the UK to control the practice of psychotherapy ...” (Sieghart, 1978:5).

However these views are refuted in the “Note of Dissent” by the British Association for Behavioural Psychotherapy at the end of the Sieghart report which states that:

... the [Sieghart] report cites opinion by the Royal College of Psychiatrists and by the British Medical Association that psychological procedures cause harm if carried out by unqualified practitioners. In fact evidence is lacking that harm occurs to members of the public through psychotherapy being given by unqualified as opposed to qualified practitioners at the present time.... (ibid.:17)

This is a state of affairs that, as far as I am aware, is still the case.

The Sieghart Report is not the report of a government sponsored body nor an independent inquiry but rather is essentially a discussion paper rep-

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resenting the views of the analytic lobby (Freudian and Jungian) at that time, along with those of the psychiatrists, and in the separate note, the dissenting views of the behaviour therapists. The latter argued that since there was no clear evidence of the efficacy of psychotherapy it should not be given the honour of statutory recognition. According to John Heron, who as Assistant Director of the British Postgraduate Medical Foundation was *au fait* with these matters at the time, their opinion was more vociferous in private: “[The behaviour therapists] also said, in more radical tone, that psychoanalysts in particular were hypocritical in wanting to protect the public from transference abuse, when their own therapy was riddled with this very phenomenon.... What the psychoanalysts really wanted, said my behaviour therapy sources, was to manoeuvre the government into protecting their lucrative monopoly on transference abuse. Strong stuff indeed but with an important grain of truth, in my judgement and experience ...” (Heron, 1990:17).

Various other bodies (including the newly formed British Association for Counselling) were also invited to comment on a draft of the report, but there is no indication in the report as to what comments were made by them nor to what extent their views were incorporated into the final version.

In 1981, on the basis of the Sieghart Report, MP. Graham Bright introduced his Private Member’s Bill to regulate the practice and profession of psychotherapy and related disciplines. This bill failed at the second reading because the government had been advised that there was too much dissension in the field to warrant statutory intervention and consequently ensured that there was no time for the bill to be taken up (ibid.:18). The failure of the Bright Bill was part of the inspiration for the ‘Rugby Conferences’ out of which UKCP was eventually to come forth.

It seems ironic to me that the path to the proposed statutory registration of psychotherapy in the UK had its first step with an inquiry into the activities of a group which does not now use the term ‘psychotherapy’ and is organized as a religion and therefore unlikely to be much affected by any legislative restrictions that may arise.

In fact, Hubbard set up the Church of Scientology in the early 1950s specifically to be free to explore the world of the mind without being subject to licensure and to defend his ‘Dianetics: the modern science of men-

tal health' (Hubbard, 1950) from the hostility of the American Medical Association which, in secret alliance with other members of the US establishment, was seeking to destroy the movement:

... the American Medical Association was not amused. When newspapers quoted Hubbard as saying that Dianetics could cure all manner of ills from asthma to sex deviation the AMA accused Hubbard of quackery and of encouraging unqualified persons to dabble in psychoanalysis armed with no more than a diploma in Dianetics. When Hubbard publicly denounced practices such as electroconvulsive shock therapy and lobotomy as crude assaults on the brain, the psychiatric establishment was outraged. A surreptitious war began. Closed meetings were held with Hubbard's name on the agenda. The assistance of government agencies was enlisted - the Food and Drug Administration, the FBI and even the Attorney-General of the United States. So much trouble over the activities of a quack.... (Percy, 1987)

In 1963 the American establishment's campaign against Hubbard and Scientology came out into the open. The FDA raided the movement's headquarters in Washington and books were seized along with Hubbard's 'E-Meters' ('electro-psychometers') which were designated as 'quack devices' (Percy, 1987). The FDA applied to the District Court for permission to destroy the seized material: "on the grounds that the E-meters were 'devices' with accompanying 'false and misleading labelling' and lacking 'adequate instructions for use', contrary to the Food Drug and Cosmetics Act 1964" (Foster, 1971:59).

For anyone who is familiar with the persecution of Wilhelm Reich's Orgonomy by the FDA and US medical organizations during the same Cold War period of American history, this story will have a familiar ring.

In the light of what we now know about the nature of American institutions at the time, for example the FBI under Hoover and the excesses of the US psychiatric profession in the fifties, this would seem to be at best a case of 'the pot calling the kettle black'.

Since the late 1950s Hubbard had been running Scientology from England where he had felt safer from attack than in his homeland. How-

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ever by 1966 questions were being asked about Scientology in the House of Commons, to be followed by the press campaign and the Aliens Order already mentioned - and Foster's inquiry.

Whilst the Scientology organization was undoubtedly authoritarian in form, one wonders to what extent the exaggerated response to Scientology in the UK was 'seeded' by the hostile American establishment and also to what extent both the more 'cultish' developments in the Church of Scientology and the development of Hubbard's own 'paranoia' (as in the case of Reich) were actually 'fostered' by the vilification that they received. As Hubbard himself said: "Society tolerates far worse than we are" (Hubbard, 1966).

It bears repeating that these two reports, Foster and Sieghart, are the supposed historical underpinnings for the current proposals for statutory regulation embodied in UKCP. In the next chapter I will explore the nature of this 'organization of organizations'.

Chapter 6

The Nature of UKCP

By a sort of creeping putsch, the UK Council for Psychotherapy has established itself and its register at the centre of the therapy world in this country. This is against the will of a number of practitioners....

(Nick Totton, 1994a:47)

As with the parallel debates going on during this period [1970s to date] concerning the registration of psychologists, effected [for chartered psychologists] in 1987, those arguing for the need for regulation [of psychotherapy] emphasized the protection of the public and underplayed the issue of professional self-interest (protectionism, kudos, status, salary improvements etc.). Such is the way of professionalization exemplified in the maturer professions like law and medicine, that public interest not self-interest tends to be the hallmark of official statements and rhetoric....

(Pilgrim, 1990:13)

When in 1990 I first attempted to find out something about the nature of UKSCP directly, by writing (privately) for information, the response that I got informed me that UKSCP “is an organization of organizations and cannot at present answer queries from individuals” (UKSCP, 1990). Rather more information is now available directly to members of the public. One can send off for a brief descriptive leaflet and a directory of member organizations. A list of registered practitioners is also now available. Since July 1993 a newsletter has been available to members of the organization and is published twice a year.

Status

UKCP is a registered charity, having achieved that status (as UKSCP) in 1989. The major advantages of becoming a charity are largely financial. Being a charity brings tax advantages, rate relief, and an enhanced capacity for fund raising through public appeals, donations and, more importantly, access to grants (Phillips, 1979:2). One might suppose that a professional organization seeking a statutory monopoly would be rather too political to become a charity and accrue these financial advantages, given that: "... a body which has an object to change the law in some way, will not be registered as a charity. Further, regardless of its objects, if the main weight of a charity's activity is directed to changing the law it is acting outside charitable limits" (ibid.:46).

However, although clearly a main aim, acquiring statutory privilege is not one of UKCP's explicit objectives in its constitution (see below).

The issue of political activity by charitable bodies is something of a grey area. According to the Charity Commissioners (1994), the Courts have held that seeking to change the law or government policy are certainly political activities rather than charitable ones. Nevertheless, a charity may engage in such political activity but its freedom to do so is quite restricted. Any political activity undertaken by a charity must be in furtherance of *and* ancillary to the objects stated in its governing document. 'Ancillary' means that political activity must serve and be subordinate to those objects and not the main aim of the organization: "... They cannot, therefore, be undertaken as an end in themselves and must not be allowed to dominate the activities which the charity undertakes to carry out its charitable purposes directly ..." (ibid.:6).

There is an onus on the charity to show that its political activities are likely to further its charitable objects: "... The trustees must be able to show that there is a reasonable expectation that the activities will further the purpose of the charity effectively and so benefit the beneficiaries" (ibid.). "... It is not sufficient for the trustees simply to *believe* that their activities will effectively further the purposes of the charity; there must be a *reasonable expectation* that this is so ..." (ibid.:16).

Consequently, whilst a charity *may* seek to influence public opinion or promote a change in government policy it must not do so on the basis of "... slanted and inaccurate data. This is particularly important where mate-

rial which arouses emotion is used” (ibid.:10). “A charity must not issue information which is biased” (ibid.:13). Regarding the publication of research by a charity: “... Where solutions requiring political action are advocated, they must arise from a proper analysis of the research findings ...” (ibid.:13). Thus charities are supposed to present balanced information in support of their political activities, not propaganda.

In sum, it seems that, as a charity, for UKCP to legitimately pursue statutory registration this must be a subsidiary activity not its primary objective and there is an onus upon it to present a well-founded case that statutory registration would, in truth, further its charitable objectives as set out in the ‘objects clause’ of its constitution and benefit the public. This case would, in the interests of the unbiased presentation of evidence that behoves a charity, also need to address the arguments and evidence presented in this book and elsewhere which indicate that there are by no means grounds for a “reasonable expectation” that such a change in the law in the case of psychotherapy would in fact benefit and protect the public rather than simply serve the economic and professional interests of the practitioners and trainers of which UKCP is largely composed.

History

UKSCP, the UK Standing Conference for Psychotherapy finally sat down and became the UKCP, the UK Council for Psychotherapy, in early 1993. UKSCP came into being in 1989, growing out of an annual conference known as the ‘Rugby Psychotherapy Conference’ that was first organized by the British Association for Counselling in 1982. In the previous year, MP Graham Bright’s Private Member’s Bill (based on the recommendations of the Sieghart Report), had failed at the second reading (Heron, 1990; UKCP 1993b). According to Derek Gale:

In the 1980s, prompted by the scare over Scientology, which had precipitated very narrow and unconsidered legislation in Australia, and the subsequent Sieghart report in this country, many psychotherapists feared Government interference and the imposition of controls on psychotherapists. The Sieghart Report was

heavily slanted in the direction of psychoanalysis and other psychotherapists feared that their views would not be considered¹.

Out of this fear emerged the Rugby Conference, which was organized by the British Association for Counselling, as a neutral body acceptable to all those attending. This became an annual meeting. (Gale, 1989:102)

The BAC has since bowed out of this particular arena (although it remains a “Friend of the Council”) and in conjunction with other counselling organizations is pursuing a separate register for counsellors.

Aims (see also - “UKCP aspirations” below)

After seven preparatory years of ‘Rugby’ Conferences, the United Kingdom Standing Conference for Psychotherapy (UKSCP) was formally established in 1989, with the intention of becoming the national Council for the profession of psychotherapy. *Having as its primary aim the protection of the public from unqualified practitioners* (UKSCP, 1992)

UKCP’s “Aims and Objectives” as set out in its constitution (which are therefore its ‘charitable objects’ as accepted by the Charity Commissioners) are as follows:

- (i) To promote or assist in the promotion of the preservation and protection of public health by encouraging high standards of training and practice in psychotherapy and the wider provision of psychotherapy for the public.
- (ii) To promote for public benefit research and education in psychotherapy and to disseminate the useful results of any such research.

In furtherance of the above objectives but no further or otherwise the Council shall have the following powers:

- a) To encourage the exchange and understanding of the different theories and practices within psychotherapy.
- b) To represent the organizations whose members engage in psy-

chotherapy to other professions, institutions and to the Government.

c) To do all other things as shall further the above objectives.
(UKCP, 1993a:1)

As mentioned in Chapter 2, safeguarding the public from harm by weeding out the unqualified is the standard argument put forward by groups seeking the legal privileges of a statutory profession. In newspaper articles coinciding with the launch of the UKCP register, those who are regarded by UKCP as unqualified have been referred to by the pejorative label ‘charlatans’ (“imposter in medicine, quack” - *Concise Oxford Dictionary*, 4th edn.), a smear tactic borrowed from the allopathic medical profession where this term has been frequently used to discredit alternative practitioners. (See e.g. Illman, 1993; Pepinster, 1993.)²

The validity of this claim to be safeguarding the public will be explored in depth in later chapters, but let me just note here that the historical run-up to UKCP is, from the practitioners’ position, characterized more by fear, competition and rivalry than by altruism.

It is also noteworthy that UKCP has established itself without apparently offering a public definition of ‘psychotherapy’, the activity which it seeks to oversee. The nearest thing to a definition that I could find in available UKCP documents was:

All psychotherapists are expected to approach their work with the aim of alleviating suffering and promoting the well being of their clients.... (UKCP, 1993d & e)

John Rowan seems to regard this sort of vagueness as a virtue: “... The reason why this has been possible [the holding together of UKSCP] is that it is not agreement on theory which is being attempted, but agreement on staying together so that the UKSCP can be recognised as the only competent authority in the UK which can speak for all psychotherapists ...” (Rowan, 1991:33).

This lack of definition may be good for the acquisition of power, but it is not exactly a point in favour of the legitimacy of the authority to which

UKCP aspires. By avoiding the tricky but fundamental issue of defining psychotherapy, the dissension in the field mentioned above (which inhibited governmental support for legislation last time), is glossed over in the interest of acquiring statutory privilege. Thus the boundaries of this activity which is UKCP's concern have not yet been drawn.

In countries where some form of statutory registration in this sort of area has been introduced (such as Australia and the USA), it is not unusual for a clear definition of the occupation to be omitted from the legislation other than to define it in a circular fashion such as: 'a psychologist is someone who is on the psychologists register' or to do so in so broad a fashion as to make it difficult to know what might *not* be covered. Such legislation leaves tremendous discretionary power in the hands of the registration board. (See also Chapter 12, Appendix B and Hogan, Vol. 2, 1979.)

However UKCP is now coming under pressure from The Lead Body for Advice Guidance and Counselling and from the BAC in regard to this issue of specifying the boundaries of psychotherapy (see Chapter 19).

This question of the definition and delimitation of the field regarded by UKCP as psychotherapy is important. In particular it impinges upon the right of human potential practitioners (and others who do not regard themselves as psychotherapists) to practise outside the UKCP structure if UKCP were to gain title protection and eventually attempt to go beyond title protection to a control of practice as well (see Chapter 24).

Structure

UKCP regards itself as having a 'federal' structure (UKCP, 1993b). Similar kinds of psychotherapy are grouped together in sections. There are currently eight of these: The Analytical Psychology Section, the Behavioural and Cognitive Psychotherapy Section, the Experiential Constructivist Therapies Section, the Family, Marital, Sexual Therapy Section, the Humanistic and Integrative Psychotherapy Section, the Hypnotherapy Section, the Psychoanalytic and Psychodynamic Psychotherapy Section, and the Psychoanalytically-based Therapy with Children Section (*ibid.*). Most member organizations associated with humanistic psychology are part of the Humanistic and Integrative Psychotherapy Section known as 'HIPS'.

Sections have a duty to meet at least twice a year, to organize them-

selves as they judge appropriate, to consider applications for membership in conjunction with the Governing Board, to approve the Codes of Ethics and Practice of member organizations and to process complaints and appeals (UKCP, 1993a).

In addition there are categories of Special Membership, Institutional Membership and non-voting categories of Associate Membership and Friends of the Council. The Special Members of UKCP are the British Psychological Society and the Royal College of Psychiatrists. Special members are Full Members of the Council and each has a seat on both the Governing Board and the Registration Board. The Institutional Members of UKCP are the Association of University Teachers of Psychiatry and the Tavistock Clinic. Institutional Members are Full Members of the Council and have two seats on the Governing Board and one seat on the Registration Board (*ibid.*). These latter two are apparently to be joined by a new Institutional Member, the University Psychotherapy Association, which will provide a direct route onto the register for graduates of university courses in psychotherapy (UKCP, 1993i). The BAC is a Friend of the Council, not a Full Member, and therefore has no voting rights (UKCP, 1993f). Associate Membership is a category for organizations which are not eligible for, or not wanting, Full Membership (UKCP, 1993a).

Membership

Membership of UKCP is only available to organizations and not directly to individuals. In addition to the Special, Institutional and Associate Members listed above, there are currently 68 member organizations in the Sections (Pokorny, 1994:517). Prospective organizations must:

1. Possess an accountable administrative structure, such as a constitution, compatible with that of UKCP (UKCP, 1993a:3).
2. Be the: "largest composite body, relevant to psychotherapy, of immediately related organizational units, and not a branch or sub-unit of a larger body eligible to join in its own right;
3. ... possess a membership, of any standing, of no fewer than fifty persons;
4. ... have been in existence for at least three years" (*ibid.*).

In making an application for membership: “Organizations mainly concerned with practice or teaching will describe their practice and their selection and training procedures, including length and frequency of training, requirements for personal therapy if any, and methods and standards used to evaluate trainees. Other organizations must show that they contribute to the development of psychology or psychotherapeutic work, either by accreditation, or by the promotion or maintenance of high standards of practice or teaching, or other promotional activities” (ibid.:5).

However, any organization that declared an interest in UKSCP and attended at least one ‘Rugby Conference’ prior to the inauguration of the Standing Conference in 1989 was allowed to become a Full Member without having to meet the above criteria (ibid.:7).

Membership of UKCP is subject to a ‘sunset clause’ under which the grounds for membership of each member organization are reviewed every five years (ibid.:8). I presume that this is unlikely to affect the Special and Institutional Members.

A quick survey of the 1993 membership of the eight Sections of UKCP reveals that they are virtually all practitioner organizations and that approximately 90 per cent of them are training and/or accrediting organizations.

Training organizations have a particular vested interest in participating in registration schemes like UKCP’s, especially when a bandwagon has begun to roll. In a climate of uncertainty about the future right to practise and misinformation about the actual risks, prospective trainees may avoid organizations which are not ‘approved’. Thus both training organizations and prospective trainees are under pressure to board the bandwagon whatever its merits. Through the support it gives to an organization like UKCP, such an ‘insurance’ mentality actually increases the risk of a restriction on title and/or practice that it is intended to indemnify. Moreover, whereas “interested organizations” - original participants in the ‘Rugby Conferences’ - are exempt (until their ‘sunset’ review) organizations who join subsequently must fulfil the above criteria of a minimum of three years establishment and a minimum membership of fifty. As Michael Wibberley has pointed out to me (1994a), the more established UKCP becomes and the more it is perceived as presaging some form of statutory control, the harder it may become to start up a new training organization,

since potential trainees cannot be guaranteed eventual access to the register unless the organization is a UKCP member and the organization cannot become a member unless it has been running long enough and has enough graduates or trainees. This vicious circle for new organizations could effectively ‘freeze’ training in the hands of the established members and thereby stifle innovation.

The boards

There are two boards in UKCP, the Governing Board and the Registration Board. The Governing Board is the central authority of the organization and is responsible for carrying out the decisions and policies of the Council, for convening the AGM and other meetings, for vetting applications to join the Council, for appointing sub-committees and for all forms of public representation (UKCP, 1993a; Pokorny, 1994)

The Governing Board is composed of a delegate from each of the eight sections; a delegate from each of the two Special Members; two delegates from each of the two Institutional Members; five officers and four ordinary members elected at the UKCP AGM from amongst the delegates (*ibid.*). These elections are on the basis of a two-thirds majority vote, as are other decisions at the AGM (*ibid.*). The Chairs of the Registration Board and the Training Standards Committee are also due to become Officers of the Governing Board since the existing structure has proved to be unworkable (UKCP, 1994).

The Governing Board is *entirely* composed of delegates of Member organizations: “No person shall be an officer or member of the Governing Board unless he or she is a representative of an organization that is itself a Full Member, Special Member or Institutional Member organization of the Council” (UKCP, 1993a:2).

The Registration Board set up in January 1993 administers the register according to regulations determined by the Governing Board, monitors complaints received by member organizations and: “reviews the registration of any psychotherapists if grounds for doing so are put before it” (*ibid.*).

The Registration Board is composed of a delegate from each of the Special and Institutional Members and: “delegates from the Sections in

the ratio of one delegate for every ten or part thereof accredited training or recognized accrediting organizations in that Section. Only delegates of accredited training organizations, or recognized accrediting organizations may serve on the Registration Board ...” (ibid.).

Thus, like the Governing Board, the Registration Board is *entirely* composed of delegates of member organizations and in this case, apart from the Specials and Institutionals, *entirely composed of training or accrediting organizations*. The Registration Board is neither answerable to the Governing Board nor to the Council as a whole in the AGM (Pokorny, 1992:26; 1994:517). There is no appeal against it (Collis, 1994b:8).

Power and representation

UKCP is essentially an exclusive club for psychotherapy trainers - a political lobby for the psychotherapy training business.

There is no representation of the public interest on the Boards of UKCP. There are no votes for consumer groups with an interest in this area (though apparently there is some sort of liaison with MIND (UKCP, 1993i). Clients/patients (past, present or future) do not have any representation. Students/trainees on psychotherapy training courses do not have an independent voice in UKCP. Graduates of training organizations are only represented via the organization where they trained unless a separate graduate organization has been established and admitted to UKCP (as in the case of graduates of the Westminster Pastoral Foundation) or there is some other option in their section (such as is provided by AHPP in the Humanistic and Integrative Psychotherapy Section). The non-training practitioner is barely represented in UKCP. For example as we have seen, the Registration Board is the exclusive province of training and accrediting bodies.

In sum, there is little involvement of the public interest, the consumer interest, the client interest, the trainee interest or the non-training practitioner interest in the core institutions of UKCP. Compare the above composition of UKCP Boards with what Hogan has to say about the make-up of regulatory bodies:

The design and administration of regulatory policies and programs should not be dominated by professionals, but should be

controlled by a balanced representation of appropriate constituencies ... normally including the public, professionals, government officials, clients and other affected parties. No group should have the power to dominate, unless it is to be members of the public. This is in recognition of the fact that regulation is primarily designed to protect the public. It also recognizes the historical fact that the professions may not act in the best interests of the public when their economic position is threatened. (Hogan Vol. 1, 1979:365)

Even the Foster Report argued that the governing body of a psychotherapy profession should include: “a number of radically-minded laymen who will act as leaven” (Foster, 1971) and as described in Chapter 5, the Sieghart Report, following Foster’s recommendation, called for a substantial ‘lay’ membership of the order of one quarter of the Council. Granted UKCP is not a statutory body, but the current arrangements hardly bode well should it become one.³

Criteria for the acceptance of training organizations:

The agreed baseline criteria for acceptance of training organizations into the Council are:

Graduate level entry, M. A. equivalent content, supervised treatment of clients, and training in the appropriate management of the trainee’s own involvement in the therapy process (Pokorny, 1992:25)

Apparently “graduate level entry and M. A. equivalent content” does not necessarily mean that you have to have a degree to train, but rather that the content of the training should be at a postgraduate level. This sounds rather ambiguous to me. The rationale seems to be directed at elevating the academic content and status of the courses. One organization is known to have rejected applicants who have a degree, but not one in psychology, on the grounds that their right to practise in the future cannot be assured without a degree in psychology.

Criteria for those who actually do the training, as contrasted with the requirements of their courses, do not appear to be specified. In fact, the criteria for the Humanistic and Integrative Section actually stipulate: "... We are not necessarily concerned with the credentials and intentions of the organization's founders or present directors ..." (UKCP, 1993j). Thus the amount of experience someone should have before beginning to train others is not referred to. It is not uncommon for people who have quite limited experience, having completed their own training a year or so before, to be training the new intake of their Alma Mater or setting up their own training organizations (see also Appendix F).

As we have seen, UKCP is an organization of organizations and overwhelmingly an organization composed of training organizations. Practitioners gain access to UKCP and its register via membership of a constituent organization. In most cases, this will be the organization with which they trained. In addition, as currently structured, the complaints procedures [see below] operate in the first instance through the member organizations, that is in most cases through the organization with which the practitioner trained. A consequence of all this seems to be that practitioners never really sever the 'umbilical cord' between themselves and those who trained them - if they want to stay on the register. This would appear to leave a great deal of power in the hands of the trainers. Given that training organizations are the ones largely responsible for setting up the whole UKCP edifice, I suppose that's not very surprising (see also Chapter 18). The vast majority of the training organizations involved, including those in the Humanistic and Integrative Section, train people to practise individual psychotherapy rather than group work - a very different skill. Will a separate register for group leaders be proposed?

Training standards

The UKCP Training Standards Committee was established in January 1993 to: "advise the Governing Board from time to time as to what regulations are appropriate for the registration of psychotherapists by the Council and other matters of training" (UKCP, 1993a:5). The constitution is rather ambiguous on this point, but the composition of the committee appears to parallel the 'in-house' pattern of the other core institutions of UKCP. The

Committee is appointed by the Governing Board, with half the membership nominated by the Registration Board (ibid.). The Training Standards Committee seeks to raise the standard of the minimum requirement that any training will have to meet, including: “UKSCP requires member organisations to ensure that training as a psychotherapist includes the acquisition and maintenance of a level of competence in self-awareness regarding conscious or unconscious processes, demonstrably appropriate to the type of therapy practised” (Pokorny, 1992:26) [How pray?].

David Wasdell has convincingly suggested that the processes of professionalization and accreditation that concern UKCP serve the unconscious societal task of defence maintenance and are forms of collusional countertransference (Wasdell, 1992:13). If so, those involved in UKCP are caught in a fundamental ‘Catch 22’: If they are so unaware as to engage in such a process they have failed to demonstrate the necessary competence cited above and are *ipso facto* too incompetent to be part of the profession they aspire to, since they do not meet their own standards!

The trend in training requirements sponsored by UKCP seems to be towards longer training courses (four or five years), increased academic content, more uniform standards of training to stay in line with the particular UKCP section, and for what were recommended prerequisites and aspects of content to become requirements.

There is strong support at the conference for everyone on the register having to do a ‘mental health’ placement and those organizations which are recognized by the UK Conference as training organizations have until 1994 to implement this requirement. There is a strong feeling that this should lead to training programmes of four years duration. There is also a strong feeling that only graduates should be taken on as trainees. (AHPP, 1991a)

For some time there has been a significant shift towards a more uniform standard of training by a subtle kind of upgrading that has gone on almost unnoticed. In order to stay in line within their own section, member organizations have been adjusting their training requirements. Two examples: one organization in the Analytic Psychotherapy Section used to recommend that its

trainees have own therapy, now they demand it. One of the Jung trainings used to require twice-weekly analysis, now it requires thrice. We have kept a steady pressure on the sections to produce criteria that are distinctive and satisfactory. (Pokorny, 1992:25)

UKCP ‘standardization’, if given the statutory ‘seal of approval’, could stymie alternative forms of training such as apprenticeship (see Chapter 18).

As mentioned above, the vast majority of organizations accredited by UKCP do not offer courses that train people to do group work.

Codes of ethics and practice:

Psychotherapists on the UKCP register are required to adhere to the Codes of Ethics and Practice of their own member organization which must be consistent with UKCP Ethical Guidelines and approved by the appropriate UKCP section. As guidelines, some of these would not be quibbled with by any person of integrity and would be inherent in an honest relationship. In effect they amount to: be ‘upfront’ and honest about your background and terms; respect your clients; put their interests first; don’t exploit them.

The guideline concerning contact with professional third parties holds that: “Psychotherapists should consider the client’s best interest when making appropriate contact with the client’s GP, relevant psychiatric services, or other relevant professionals. Psychotherapists should be aware of their own limitations” (UKCP, 1993e).

This represents a significant liberalisation of the earlier version which assumed a closer working relationship with the medical profession: “It is normally desirable that psychotherapists should notify the client’s General Practitioner that the client is in treatment ...” (UKCP, 1993d).

Other guidelines represent requirements that are more problematic. For instance: “Psychotherapists are required to ensure that their professional work is adequately covered by appropriate indemnity insurance” (UKCP, 1993e). This begs quite a lot of questions about ‘standards’. Note that professional indemnity insurance is *required* rather than say ‘encouraged’ as in the BAC (see Chapter 21).

Furthermore, UKCP psychotherapists: “are required to refrain from any behaviour that may be detrimental to the profession, to colleagues or to trainees.” (ibid.) and UKCP psychotherapists: “are required to take appropriate action in accordance with Clause 4.8 with regard to the behaviour of a colleague which may be detrimental to the profession, to colleagues or to trainees” (ibid.).

These two are standard clauses used by professions to protect the reputation and public image of the profession. Who decides what is detrimental? The profession, of course.

Complaints and disciplinary procedures

Each UKCP member organization is required to have a Complaints Procedure approved by the appropriate UKCP Section. A client wishing to make a complaint against a psychotherapist initiates the procedure of the relevant member organization. “After the completion of the Complaints Procedure within an organization, an appeal may be made to the Section *on the grounds of improper procedure*” (UKCP, 1993g:4). Appeals (on the grounds of improper procedure) not resolved by the Section are referred to the Governing Board which has the power to appoint an Appeals Committee: “as need arises” - i.e. on an ad hoc basis (UKCP, 1993a:5). The composition of the Appeals Committee is agreed amongst the parties where possible, but if not, the Governing Board decides. The views of this Committee are to be taken into account by the Registration Board but are not binding on it (ibid.).

If someone is sufficiently *compos mentis* to negotiate this complaints process, I imagine they also could cope with anything a dodgy therapist might throw at them.

However, although currently: “... Registration is through the Sections and the organizations and is not done on an individual basis. That is because the Register is voluntary. A statutory register would be managed quite differently and on an individual basis; any complaints would go to the disciplinary committee of the register” (Pokorny, 1994:517). This would result in a much more centralized system.

If UKCP’s register were to become statutory, its complaints and disciplinary procedure could become a quasi-judicial process in itself, al-

though set apart from the main body of the justice system with the latter's checks, balances and rules of evidence, standards of proof and investigation, and open courts. Yet it could have the power to remove someone's livelihood, including for things judged by the profession to be detrimental to the profession. Whether this process would constitute a 'palace of justice' or a 'kangaroo court' is a moot point.

The register

UKCP's 'National Register of Psychotherapists' is even more presumptuously titled than the organization itself, reflecting aspirations rather than current reality. The register comprised some 2600 practitioners when launched in May 1993. It was presented to Tim Yeo, who was then Parliamentary Under Secretary of State for Health before being forced to resign from the government in the midst of the 'family values' policy débâcle. In his speech to mark the event, Yeo cited sexual misconduct amongst psychiatrists and psychologists as giving rise to public concern (Yeo, 1993).

The launch of the register was celebrated by about ninety people in the 'Moses' Room of the House of Lords (not the Commons let us note) at the invitation of Lord Clinton-Davis (UKCP, 1993h). The event received considerable press coverage and a cursory reading of these press accounts might lead one to believe it had become law, however it is important to realise that the register was *not* passed into law but merely *celebrated* in the House of Lords. Good PR though.

But any hopes that statutory recognition of the register would follow in the near future were dashed by Mr. Yeo who said that the Government, although strongly supportive of the efforts being made to regulate the profession, was reluctant to contemplate legislation to make the register a statutory one. (*Ham & High*, 1993)

Tim Yeo also made it clear at the launch that government would only negotiate about registration with a unified psychotherapy profession (UKCP, 1993i).

Those of us who are not keen on the idea of a 'united profession', may take heart from the fact that in addition to all those opponents of

statutory registration that the government has yet to become aware of, a group of psychoanalytic organizations have broken away from UKCP to form their own ‘umbrella’ (Pepinster, 1993; *Ham & High*, 1993) and take exception to UKCP’s claim to be: “now firmly established as the national umbrella organization for the entire psychotherapy profession” (BCP, 1994) (see also Chapter 7).

The UKCP register currently totals 2800 practitioners (UKCP, 1994). Since its inception, UKCP is in a position to derive a significant new income from the fees that practitioners must pay to go on the register. Some of that income will no doubt be used to fund continued political lobbying for a change in the law (see also Chapter 2).⁴

UKCP aspirations: title protection

The UKCP register of psychotherapists is currently a voluntary one without any legal backing. The organization clearly intends to try to make its register a statutory one involving restriction of the use of the term ‘psychotherapy’ to those on its register, a move which would obviously require government backing:

We want statutory control but we are not getting it. So the only option is to have voluntary control. It will help, but there will still be nothing easier than for a charlatan to set up shop and get clients. They will be beyond our control. (Emmy van Deurzen-Smith, UKCP chairwoman, 1993)

... the register is voluntary and in itself will not bar the untrained and the unscrupulous. They will be free to practise as before. The UK Council wants the use of certain titles such as “psychotherapist” to be restricted by law to members of the register. This would put psychotherapists on a similar footing to doctors. (It is a criminal offence for anyone to claim to be a registered medical practitioner without a primary medical qualification.) (Illman, 1993)

It is worth noting as an indicator of the power of statutory registration of title alone, that in the UK, unlike say the Dental Register where a practice

act applies, the Medical Register actually only distinguishes between qualified and unqualified practitioners (i.e. represents a title act). With certain exceptions anyone may practice medicine with impunity (as long as they do not call themselves a 'Doctor', 'Registered Medical Practitioner', 'General Practitioner', or 'Surgeon'). And yet, thanks to the influence of the NHS over fee payment and public reluctance to employ the 'unqualified', very few unregistered allopaths exist. Moral: Do not underestimate the power of labels!

UKCP's register seeks to protect the public from the 'unqualified'. If it becomes statutory and a title act is thereby invoked, it is likely to draw upon this public reflex of equating 'qualified', 'registered' practitioner with competence even though in this field, as we shall see, the equation does not hold. Even if the health system moves further in the direction of private health insurance, similar factors are likely to apply (see also Chapter 20).

In addition to seeking to convert the term 'psychotherapist' into a protected title, UKCP is also planning to reach agreement within itself upon the labels, by which the different modalities practised by its psychotherapists are to be known (Pokorny, 1992:27). Thus, there may be an effort to legally restrict the use of other labels (besides 'psychotherapy') to those on its register.

Furthermore, as previously mentioned, the British Psychological Society, which is one of the institutional members of UKCP, is simultaneously pursuing a statutory register of 'psychologists' (see also Chapters 2 and 7).

UKCP aspirations: beyond title protection?

Writing in 1992, David Jones, editor of *Self and Society*, had the following to say:

In three to ten years time UKSCP will have got its procedures in place and will press for formal recognition by the British Government. If that happens, as it probably will, only people registered with UKSCP will be able to call themselves psychotherapists and practise as psychotherapists in Britain. And of course

any EC citizen may register, if they fulfil the requirements, and they too may then practise in this country.

If the law changes so that you must be registered with UK-SCP in order to call yourself a psychotherapist then what happens if you practise something which other people say is psychotherapy but you do not call it that yourself? You might for example say you are a Gestalt therapist. Under Common Law in Britain you may do this providing your clients consent and you do not claim to cure anyone of anything [I believe this is true for cancer and some other conditions such as venereal disease but that it is not generally the case]. I do not know whether the EC will try to regulate practice in such a way that you would be prevented from this loop hole - is it a loop hole? *Self and Society* has been told that in some EC countries, Germany for example, you are liable to prosecution if you are deemed to be practising anything for which you must register even if you call it something else. Does UKSCP intend to push for that arrangement in Britain or is it only the name psychotherapist rather than the activity which they want subject to legal control? (Jones, 1992:1)

Clearly UKCP is promoting a 'licensing' system, specifically a 'title act', perhaps eventually a 'practice act' and that therefore the full weight of the arguments that follow regarding licensing would apply to the statutory arrangements that UKCP seeks.

Chapter 7

UKCP in Perspective - Other Register Builders

... it is the nature of psychotherapy that none of the existing professions can legitimately claim a monopoly on it...

(Jeremy Holmes and Richard Lindley, 1989:214)

... Because of its ambiguous epistemological status (is it a psychological practice or medical treatment?) as far as ownership is concerned, psychotherapy has been at the centre of important boundary disputes and conflicts between professional groups inside the mental health services over the past twenty years....

(David Pilgrim, 1990:12)

In 1990 counselling obtained official recognition as a treatment in the UK when the then Minister of State at the Department of Health agreed that family health service authorities could offer GP's between 70 and 100 per cent reimbursement of the costs of hiring counsellors and other ancillary workers to work in their practices. From then on their numbers were calculated to grow in the NHS and, many counsellors hope, within five years an official register of counsellors will confer legal privileges on the profession.

(Myles Harris, 1994:9)

About 40,000 people are officially estimated to work full time in the area of 'advice guidance and counselling' (Harris, 1994:11). As mentioned in the previous chapter, UKCP comprises 67 member organizations plus one 'friend' (UKCP, 1993g) and currently has 2800 psychotherapists registered (UKCP, 1994). Other organizations with an interest in register building are:

The British Association for Counselling (BAC)

BAC was formed in 1977, only one year before the Sieghart Report was published and has expanded rapidly since then, growing by approximately 300 members per month in 1993 (Harris, 1994). BAC allows both individual and organizational membership and had a total membership of 10,700 individuals in 1993 (ibid.). Of these, 640 have so far gone beyond full membership to the long and involved process of becoming BAC accredited (ibid.).

BAC estimates that there are about 600 counselling courses in the UK (ibid.) and has approximately 550 organizations listed in its 1993 'Resources Directory'.

BAC is one of the members of a Steering Group for a United Kingdom Register for Counselling which it hopes will eventually lead to a statutory register (Baron, 1994:14). Like UKCP, BAC is a registered charity and therefore subject to the same limitations on its freedom to engage in political activity.

BAC does not consider that it is really possible to distinguish counselling and psychotherapy: "It is not possible to make a generally accepted distinction between counselling and psychotherapy. There are well founded traditions which use the terms interchangeably and others which distinguish them ..." (BAC, 1992). BAC has also promoted a label of 'therapeutic counselling'. (See also Chapters 12, 19 and 26.)

The British Confederation of Psychotherapists (BCP)

BCP was inaugurated on 13th September 1993 as an umbrella organization for psychoanalytic psychotherapists, independent of UKCP.

Its register of approximately 1200 practitioners was published in January 1994. It consists of ten organizational members, five of whom including the British Psycho-Analytical Society (approximately 530 practitioners) were formerly members of UKCP but broke away to establish BCP. It was felt that the structure and constitution of UKCP did not allow "appropriate differentiations" within the field of psychoanalytic psychotherapy and that: "the diversity of standards and trainings and the size of what was then

called the Analytical Psychotherapy Section (over 30 organizations) posed insuperable problems to the establishment of appropriately rigorous standards for training and practice within this field” (Richards, 1994). Four BCP members have retained membership of UKCP and therefore have a foot in both camps.

BCP claims to be a complementary rather than rivalrous umbrella to that of UKCP and has taken UKCP to task for suggesting that BCP become incorporated within UKCP and for assuming that a single umbrella is necessarily essential - or preferable. (BCP, 1994)

The medical profession has a strong presence in BCP (and in psychoanalysis generally) in that a significant proportion of its practitioners are medically qualified. In the case of some constituent organizations such as the British Psycho-Analytical Society, more than fifty per cent are medically qualified and most of these are psychiatrists. As discussed in Chapter 5, The British Psycho-Analytical Society, along with other analytic bodies, was a main mover behind the working party that produced the Sieghart Report.

The British Psychological Society (BPS)

As both a registered charity and a body holding a Royal Charter, BPS is under a double legal obligation to conduct its affairs in the public interest.

BPS has a Register of Chartered Psychologists with 7000 practitioners entered (BPS, 1993b). As discussed in Chapter 2, the designation ‘Chartered Psychologist’ already gives a form of title protection. However BPS now aspires to title protection of the term ‘psychologist’ and not for the first time - BPS had hoped to sponsor a parliamentary bill with that end in view in 1984 (BPS, 1984). As things turned out they had to put that particular ambition on the back burner.

The Foster Report actually gave the thumbs down to the statutory control of the practice of psychology, designated by Foster as the study of intellectual ability as opposed to the alleviation of emotional illness (psychotherapy) (Foster, 1971:176).

BPS is: “university and cognitive science oriented and tends to adopt a medical model of suffering - diagnosis, treatment by an expert and prog-

nosis” (*Self & Society*, 1991:28). BPS uses the term ‘psychological therapy’ to describe one of the functions of clinical psychologists (BPS, 1990, 1995). This is a term which perhaps ‘fits’ better with notions of psychologists being the ones who should do the ‘therapy’. Besides, in the context of NHS history, the label ‘psychotherapy’ has usually been associated with medical posts (Kosviner, 1994:287). However, BPS also promotes ‘counselling psychology’ as one of the services offered by its members (BPS, 1995). Counselling psychologists work with people to help them: “improve their sense of well-being, alleviate their distress, resolve their crises and increase their ability to solve problems and make decisions” and to help them: “cope more effectively with normal life cycle developmental issues, such as relationship breakdown, career change, redundancy, loss and bereavement, and illness” (*ibid.*). BPS has a ‘counselling psychology’ special group that is seeking to differentiate ‘counselling psychology’ from other sections of psychology and from other sections of counselling (Baron, 1994:14). This may prove difficult.

According to Holmes and Lindley (1989:213-5) clinical psychologists are amongst those most opposed to the establishment of ‘psychotherapy’ as a separate profession and BPS has argued that registration is necessary only for the private sector and that NHS funded therapists should all be members of existing professions such as psychology or social work.

BPS and the clinical (and other) psychologists it represents have little historical claim to legitimate authority in the field of psychotherapy generally. It was only in the 1980s that British clinical psychology began to boast the advantages of eclecticism including verbal psychotherapy (Pilgrim, 1990:7). Clinical psychology only emerged as a new profession in Britain in the early 1950s. It was not characterized by any sort of therapy until the late 1950s, when it began to champion ‘behaviour therapy’ (and later ‘cognitive-behaviour therapy’) in the course of its ‘status war’ with psychiatry and challenge to the medical profession’s monopoly of therapeutic authority in the health service (*ibid.*:7-12). Peace was largely declared after the 1977 Trethowan Report into the role of psychologists in the NHS (*ibid.*) and more recently, BPS and the Royal College of Psychiatrists have issued a joint statement proposing cooperation in the development of a coordinated psychotherapy service in the NHS (Kosviner, 1994:288). Kosviner claims that the largely behavioural bias that has pre-

viously characterized clinical psychology is being balanced out and that all major psychotherapeutic approaches (including humanistic) are now covered in the core curriculum for clinical psychology training (ibid.:299).

Apparently, it is: “the ability to combine or change psychological approaches as appropriate, while remaining rigorous in their application” (ibid.:289) that is supposed to distinguish clinical psychologists from “other practitioners of formal psychological therapies” (ibid.).

The Royal College of Psychiatrists (RCP)

The Royal College of Psychiatrists, into which the old Royal Medico-Psychological Association transformed in 1971, is amongst other things the political lobby for the psychiatrists. It has in the past been concerned to maintain medical dominance inside the state mental health services and in 1975 advised the DHSS of the importance of medical management of NHS psychotherapy services (Pilgrim, 1990:12). RCP has shown an interest in a statutory register of psychotherapists provided it has a central role in establishing and policing the register (ibid.:13). RCP is a Special Member of UKCP. As indicated above, the Royal College has signalled a willingness to cooperate with the other ‘core profession’ currently involved with the provision of psychotherapy in the NHS (clinical psychology) in order to develop a coordinated service.

Curiously, it seems that there is no publicly accessible register of psychiatrists as such. The Royal College regards itself as a members’ organization and does not give out information about its members to the general public (RCP, 1995). The statutory Medical Register does not require more than basic medical qualifications to be lodged. (See also Chapters 24, 25 and Appendix E for more on psychiatry.)

All these organizations monitor and are to some extent involved with the activities of each other. BPS, a Special Member of UKCP, is also an organizational member of BAC. BAC is a ‘Friend’ of UKCP, has organizational members in common with UKCP and has many individual members who are also on the UKCP register. BCP also has member organizations in common with UKCP. RCP is a Special Member of UKCP and a significant number of BCP members are also members of RCP.

Chapter 8

Comparisons with Other Countries

Seemingly few groups are not licensed in one state or another [of the USA]. The following sampling [of licensed occupations] from a Department of Labour study ... illustrates the wide range: aerial horsehunters, athletic exhibition agents, alligator hunters, astrologers, bedding cleaners, quail breeders, ice cream buyers, cactus plant agents, antifreeze dealers, junk dealers, dog training area operators, fortune-tellers, clairvoyants, palmists, handlers of frozen desserts, installment paper purchasers, moving picture operators, photographers, rainmakers, cemetery sales people, toy salespeople, tattoo artists, tree experts, weatherpeople and wildlife exhibit managers.

(Daniel Hogan, Vol. 1, 1979:242)

Would a statutory UKCP register be very different from other licensing systems elsewhere? A leading proponent of the involvement of humanistic organizations in UKCP has argued that what has been happening in this country is: “something quite unique and exciting” (Young, 1990:5). This is in comparison with various European countries where: “... it has been successfully argued that psychotherapy is an activity that should only be practised by other professionals such as psychiatrists, psychologists and nurses ...” (ibid.:4), or the US model where to be: “... a *licensed* psychotherapist you effectively need an M.A. or Ph.D. or to be a psychiatrist. Otherwise you are condemned to practise psychotherapy as a ‘therapist’. You cannot call yourself a psychotherapist ...” (ibid.:5).

Because of the ambiguous nature of psychotherapy, the assessment of relevant legislation in other countries is an extremely complicated business, not least the question of determining what the relevant legislation is. Often ‘psychotherapy’ is a territory claimed by various rival occupational groups which may have obtained some sort of licensing legislation in their favour. Without a country by country study of the actual statutes (which I have only undertaken in the case of Australia, Canada, the UK and some

of the US states), false impressions can easily arise. I have had to rely on secondary sources for much of my information. Regarding these, Hogan's massive study of the legal framework in the USA (Hogan, Vol. 2, 1979) seems very thorough though it only takes matters up to 1979.

The situation in Europe is particularly hard to elucidate. There are not only inter-country differences but provincial ones also. In Switzerland, for example, the status of psychotherapy is a cantonal matter rather than a federal one (Swiss Embassy, 1995). There are twenty-six cantons.¹

Regarding the European Community/Union, even the central institutions have not yet been able to obtain definitive information for all Member States. On the basis of the information acquired so far, as of 1995 it seems that a majority of the fifteen Member States of the European Community/Union do not have statutory recognition of psychotherapy as a distinct profession.² Indirect regulation by limiting access to health insurance reimbursement is as, or more, prevalent than direct forms of regulation in the European Community.³ (See also Chapters 3 and 20.)⁴

In the USA, the relevant legislation is on a state by state basis. All fifty states and the District of Columbia prohibit unlicensed practice of medicine and most medical practice acts include psychotherapy within their definition of practice, whether directly or indirectly (Hogan, Vol. 2, 1979:71). In addition all states now have some form of psychology licensing laws, all of which have been introduced since 1945. Under this legislation in some states you could practise within the law as a "therapist" as Young has stated. According to the Association of State and Provincial Psychology Boards, as of 1994 only nine out of the fifty states plus DC have psychology legislation limited to the control of title usage, that is certification laws (title acts) (ASPPB, 1994a). The rest are regarded by ASPPB as having some form of licensure law (practice act). Therefore in many states it appears that you would be practising outside the law if, given suitable definitions in the relevant act, the licensing authority chose to regard what you were doing as practising psychotherapy, whatever *you* chose to call it. For example, since the human potential movement got under way in the sixties, various US psychology licensing boards have ruled that encounter groups are already within the realm of their particular field of regulation (Hogan, Vol. 2, 1979 and Hogan, Vol. 1, 1979:248). This has presumably been a factor affecting how the human potential

movement has developed, or not, in the USA.

Hogan cautions that the legal situation regarding the right to practise psychology in the US is even more complex than it seems at first sight since, even though many state psychology laws are worded so as to restrict the right to practise, their effect may only be to prevent title usage:

... The American Psychology Association has apparently overlooked this point, since it believes that “the vast majority of the fifty [state] laws control *the practice* of psychology and are licensure laws” (APA Off. of Prof. Affairs, 1976) (emphasis added). If one looks at the actual effect of the laws, only twenty-seven make it illegal to practise psychology without a license. The other ten merely restrict practice in conjunction with representation, the effect of which is no different from state laws that only restrict the use of certain titles. (Hogan, Vol. 2, 1979:33)

No doubt by now the APA has read Hogan (unlike perhaps many of the unlicensed practitioners and their clients who will be affected) and is taking ‘appropriate steps’, which brings us to the next matter.

There has been an incremental process of amending existing state legislation to make it more restrictive or widen its scope - title acts have been converted into practice acts and definitions of applicable areas extended. As an illustration with a novel twist at the end, Kate Wylie informs me that, at the instigation of the APA, Vermont recently amended its psychology law so as to make it a criminal offence to practise psychotherapy without a licence (Wylie, 1993). However, thanks to a rearguard action by practitioners ‘outlawed’ by the new law, awareness of the issues was raised and a reamendment was subsequently passed allowing for a roster of “non-licensed and non-certified psychotherapists” that would confer a right to practise (Wylie, 1994).

Furthermore, minimum academic requirements for licensing in the USA have gradually inflated. Where a master’s degree in psychology once sufficed now a doctorate is likely to be required. Virtually all US states now require a doctorate for full licensing as a psychologist (ASPPB, 1994a).

In addition to medical practice acts and psychology acts, the would-be therapist in the USA may fall foul of statutes concerned with ‘healing

arts', 'drugless healing', 'massage practice', 'social work' and, increasingly, 'counseling'. By 1993 over half the states had introduced legislated regulation of counseling at the behest of local counseling associations and the American Counseling Association (ACA) (Alberding et al., 1993:33). The ACA apparently favours licensure (practice acts) (ibid.:36).

The situation in Canada is covered in Appendix C.

In Australia, there is no registration of psychotherapy as such, but nearly all states have psychologist registration boards, some of which have claimed that psychotherapy is a form of 'psychological practice' over which they have jurisdiction. Australia provides some useful lessons for us in Britain, given the close relationship of its legal system to our own (see Appendix B).

In countries where licensing legislation is in place, there are also issues relating to how stringently it is applied. As discussed in the following chapter, whether or not these laws are assiduously applied may depend upon whether the occupation protected thereby feels itself to be under immediate economic threat from unlicensed practitioners. Thus a 'black market' in practice may or may not flourish depending on the economic situation of the 'official' occupation, including the availability of third party funds and the degree to which access to them is monopolized by licensed practitioners (see Chapter 20).

It is certainly the case that the composition of UKCP includes a broad range of psychotherapy organizations so that if it does become the "over-seeing" organization it aspires to be, one would not necessarily have to be a member of some other profession first in order to practise as a psychotherapist or have some other profession 'in charge' - unlike in, say, the USA or *some* of Europe. UKCP does not for instance involve having the psychiatrists 'on top'. (Although this could still happen if the whole matter is referred to a Royal Commission where apparently the psychiatrists could wield more influence). Compared with *some* countries then, this is quite a liberal position and those involved can be congratulated on their system being *relatively* free from irrelevant prerequisites - compared to *some* systems of regulation abroad.

Compared with the *existing* situation in the UK however, it represents a marked deterioration. The UK situation is *already* more like the system that Hogan and others who have studied the matter recommend as

being preferable to conventional licensing systems. In many important respects a statutory UKCP system would be all too much like the systems of licensing prevailing elsewhere.

If psychotherapy regulation is introduced in the UK in conjunction with the rest of the European Community/Union, there are consequences arising from differences between the British and other European legal systems that need to be considered. Many continental European countries have legal systems derived from the Napoleonic code.⁵ Under these systems you, in effect, require legal permission to engage in a remunerative activity: "... The question about the legality of any particular mode of employment is therefore, 'Has this been legally endorsed as a remunerable activity within the public sphere?' If not, it is illegal ..." (Wasdell, 1992:7). In the UK, thanks no doubt to Wellington et al., it is generally speaking the other way around. We have the right to offer a service for reward unless the law specifically forbids or restricts it. So far, it does not in this area.

According to a legal commentator interviewed on the BBC, in countries with legal systems based on the Napoleonic code there tend to be lots of rules which are not however applied very assiduously, whereas under the British common law system there tend to be fewer rules but those that do exist are taken much more seriously. So, if European law is applied in a British way it tends to be enforced more rigorously than would be usual on the continent resulting in an *over*-regulated situation that is more restrictive than elsewhere (BBC Radio 4, 1993b). For example, the application by the UK government of EC Directives concerning food production has been judged as overzealous by continental standards and consequently many small scale UK food producers are in danger of being put out of business by the cost of conformity (ibid.).⁶ By contrast in Germany, where legislation to control alternative therapists has been in place for quite a while, I understand that there is also widespread 'underground' practice.

Compared with other countries it is the open milieu currently provided by the existing situation under British common law that is the *really* 'unique and exciting' thing! This needs to be safeguarded and enhanced - and promoted as a model for other countries to follow. In fact, the unfettered situation pertaining in Britain provides a rare 'control' for comparative international studies of the *impact* of licensing systems, a subject which I will address in the following chapters.

Chapter 9

Licensing and the Public Interest - the Purported Benefits

... The legal basis for licensure lies in the right of a jurisdiction to enact legislation to protect its citizens. *Caveat emptor* or 'buyer beware' is considered an unsound maxim when the 'buyer' of services cannot be sufficiently well informed to beware, and hence jurisdictions have established regulatory boards to license qualified practitioners. A professional board is a state or provincial agency acting to protect the public, not to serve the profession. However, by ensuring high standards for those who practise independently, the Board is simultaneously serving the best interests of both public and profession....

(Association of State and Provincial Psychology Boards, 1994b)

As we have seen, although the register operated by UKCP is currently without statutory endorsement, this is only regarded as a first stage. Like other bodies in this area, UKCP aspires to what is in fact a licensing system involving legal restriction on the use of title, if not eventually practice as well. In either case a new kind of crime would be created and it would be wise to carefully assess the consequences:

In seeking regulation, counselors [or any other occupational group] are asking society for the privilege of legal sanction. This legal sanction involves the creation of a new kind of crime and the control of certain titles, skills, and knowledge. Any attempt to control the use of skills or knowledge, especially when accompanied by a criminal penalty, may be of serious social concern. Therefore, it behooves professionals, as well as the public at large, to be well informed of the potential consequences of the legislated regulation of a profession. The gravity of the request and the consequences of the privilege cannot be minimized by

the profession without calling into question its commitment to public service and professional ethics. (Alberding et al., 1993:33)

The claim that a licensing system will enhance the protection of the public is the argument most commonly employed by professional bodies to persuade a legislature to grant that privilege. This chapter explores the means whereby licensing systems in general are supposed to protect the public and explains why all too frequently this does not prove to have been the case: "... much can be said about regulation protecting consumers, but this has not been a proven consequence of these laws (Gross, 1978; Hogan, 1979; Koocher, 1979) ..." (Alberding et al., 1993:34).

Many studies of the efficacy of licensing systems have focused on the situation in the USA where the right to pursue a vast range of occupations, from junk dealers to psychotherapists, has been restricted by a plethora of licensing laws. It may be argued that studies of US licensing systems are not applicable here. However the US context, where licensing is rampant, is ideal for studying what the effects of licensing actually *are* - unlike the situation in the UK where it is relatively untried in this sort of field. Indeed, so prevalent are licensing systems in psychological fields in the US that Hogan, recognizing the political inertia of this, has one set of recommendations focused on ameliorating rather than replacing these systems - despite their detrimental effects (Hogan, Vol. 1, 1979:372-80).

According to Hogan, licensing systems are generally supposed to benefit the public through performing the following functions: "(1) they establish entry requirements that must be met before a person enters the field; (2) they make provisions for disciplining wayward licentiates; and (3) they empower appropriate authorities to prevent unlicensed practice or title usage" (ibid.:238).

Restricting entry - excluding the incompetent practitioner

The establishment of entry requirements represents a form of what is known in economics as the 'input regulation' of a market for goods or services. It is intended to 'weed out' the incompetent supplier, thereby protecting the public from the social costs of their incompetence. This form of regulation is particularly prevalent in professional markets, where it is felt that the

costs of incompetent supply for the consumer or third parties are particularly high and that there are also high costs for the consumer in terms of the knowledge base required to be able to make an informed purchase decision - because the body of knowledge involved is systematic, sometimes arcane, and can be acquired only by long and arduous training (Trebilcock, 1982). Thus restrictive entry requirements are supposed to protect the public from the incompetent practice of occupations which involve a considerable potential for harm and yet about which the consumer cannot reasonably be expected to know enough to make an informed choice as to who is competent.

As discussed in Chapter 2 (and further addressed in Chapter 17), I do not think it is appropriate to conceive of psychotherapy, counselling or personal growth work as 'professions' characterized by an elaborate body of knowledge inaccessible to their clients nor as activities in which the practitioners act as 'agents' in the sense of doing things *for* their clients which the clients are not capable of doing for themselves. Nor are they appropriately equated with professions where practitioners act as trusted agents for the state such as when a doctor signs a certificate for death, compulsory admission to mental hospital, or a 'sick note'. If psychotherapy, counselling or personal growth work are not professions in this sense, the argument for restrictive entry requirements is correspondingly weaker.

'Input regulation' *may* be beneficial *if* the entry requirements to the market show a strong positive correlation with competence. If not, they will simply distort the market and have a negative impact:

In attempting to redress the informational deficiencies in a market, certification systems [title protection] carry a potential of their own for introducing misinformation into the market ***if inappropriate criteria are chosen for differentiating the quality of the various providers in the market....*** Moreover, certification schemes necessarily tell a consumer nothing about the quality of service to be expected from, or risks entailed in dealing with, an uncertified provider. To the extent that certification is generally taken to imply a marked quality differential between certified and uncertified providers, at the margin this is almost certainly bound to be misleading. (Trebilcock, 1982:94)

The rationales used to justify statutory regulation (e.g. specialist knowledge) also usually ensure that the regulatory mechanism is largely under the influence of the profession in question. Hence, as discussed in Chapter 4, a prevalent tendency is for entry requirements to be distorted in favour of the profession rather than in the interests of the public as a whole:

To the extent that professional interests control or influence both the setting and enforcing of licensing standards, there is a risk that the standards will be set too high in order to restrict entry unduly and drive up the incomes of existing practitioners (thus shielding them from the competition of new entrants). The emphasis placed by most professional cultures on technical excellence over other issues of service quality and over issues of cost and access is likely to increase this risk. (Trebilcock, 1982:98-9)

Subsequent chapters include a detailed exploration of the entry requirements that have been established and proposed for psychotherapy registration and the relationship of these to the the competence of practitioners.

Disciplinary action - restraining the delinquent practitioner

In addition to screening out the incompetent at the entry stage, licensing systems are intended to provide means of deterring subsequent ‘unprofessional conduct’ by practitioners. To this end, codes of ethics and practice may be promulgated and complaints and disciplinary procedures established. Grounds for revocation or suspension of a practitioner’s licence (‘struck off’ or suspended from the register) vary but usually include, in addition to professional misconduct, conviction for a criminal offence and unfitness to practise due to physical or mental illness, alcoholism or drug addiction.

Interestingly, in the case of the medical profession in the UK, the disciplinary processes of the General Medical Council do not operate in relation to an explicitly elaborated code of professional ethics but rather two broad categories: conviction for a criminal offence and ‘serious professional misconduct’ - which means: “... serious misconduct judged according to the rules, written or unwritten, governing the profession”

(General Medical Council, 1991). When serious professional misconduct is deemed to be the result of illness, for example alcoholism, the General Medical Council's confidential 'health procedures' apply and the doctor stays on the register but is not supposed to practise (BBC Radio 4, 1994b). Issues of medical negligence such as those concerned with errors of diagnosis and treatment are not generally thought to be a subject for disciplinary procedures (ibid.).

... here it has been generally felt that the patient's proper remedy is to sue the doctor for damages for his negligence, and that it is only if his conduct shows a total abandonment of his responsibilities, either towards several patients or over a period of time, that disciplinary measures are justified. (Taylor, 1976:18)

I would have thought that errors of diagnosis and treatment are perhaps the very things patients most want protection from or remedy for. After all, patients can readily notice if the doctor is drunk, read in the newspaper that he's been convicted of a crime and can charge him with sexual assault if he molests them, however areas such as diagnosis, surgical procedures or the prescription of drugs are just the sort of thing that do require the vast knowledge base acquired over many years that justifies the doctor acting on the patient's behalf. Rather than concerning themselves with aspects of medical practice where the patient is at such a huge informational disadvantage, the disciplinary proceedings of the medical profession seem to be more concerned with things that affect the public image of the profession and public 'blind' trust. However, some amelioration of this situation may result from new 'performance procedures' proposed by the General Medical Council to address cases where a doctor's 'pattern' of performance falls below an 'acceptable' level. These procedures, which would require further legislation, would however be subject to the same confidentiality as the 'health procedures' (BBC Radio 4, 1994b).

Studies of disciplinary enforcement in professions in the USA have revealed that *disciplinary action is extremely ineffective as a means of protecting the public*: "... Jervy [1961] ... concludes that between 2 and 10 percent of all physicians are involved in unscrupulous, unethical, delinquent, or incompetent activity. This is certainly nowhere near the number

of those disciplined. In the mental health professions, data from the field of psychology support the proposition that board discipline is virtually non-existent” (Hogan, Vol. 1, 1979:260).

Moreover, in the case of physicians, the most common ground for action was for narcotics: “... which accounted for 50 percent of all disciplinary actions. Most of these violations were also actionable under existing criminal law, making board action somewhat redundant” (ibid.:259). The reasons for this inadequacy seem to stem from the basic nature of the system itself rather than being something amenable to tinkering. Firstly it is very expensive to operate such a system efficiently. The appeal of licensing systems to governments is the opportunity to devolve to the profession the business of policing the profession - and the cost of doing so - while offering the public an impression of ‘doing something’. Hence adequate funds to operate the disciplinary procedures are unlikely to be forthcoming from government sources since this would negate half the appeal. Secondly, the profession typically dominates the system since it will usually be assumed that its members are those who have the expert knowledge necessary to be able to pass judgement on their peers. Of the 102 members of the General Medical Council only 13 are lay members (BBC Radio 4, 1994b). This ensures that when the system does work, it tends to do so more for the profession’s benefit than that of the public.

The problems highlighted by a study of the US legal profession by Jerome Carlin are considered by Hogan to be: “... probably typical of all licensing boards, including those regulating psychology, social work, and medicine. Carlin attempted to establish why some ethical violations led to more severe sanctions than others and why many apparent violations never met with any action ...” (Hogan, Vol. 1, 1979:260). Carlin came up with an ‘Index of Visibility’ which: “... turned out to be more important in determining disbarment than the ethical salience of the charge” (ibid.). This ‘Index of Visibility’ included as a major factor the extent to which the violation received publicity or notoriety. Carlin concluded that:

The organized bar through the operation of its formal disciplinary measures seems to be less concerned with scrutinizing the moral integrity of the profession than with forestalling public criticism and control....

Further evidence that the organized bar is responding primarily to a concern for preserving its public image is the considerable importance of the visibility of the offence to the general community.... It is consistent ... with a desire to avoid lay interference and control that the most widely publicised violations would be the most severely and publicly sanctioned. Failure to punish visible violations might result in public criticism of the bar, and the visibility itself offers the profession an opportunity to demonstrate to the public that it can discipline its own members.... (Carlin, 1966:161-2)

I have not had access to any studies that would indicate that statutory regulation in the British context is any more efficient and which would support the enthusiasm of the Foster and Sieghart Reports for this “well tried method” (Sieghart, 1978:5), which has “worked excellently in the past” (Foster, 1971:178). On the contrary, a recent investigation of the General Medical Council indicates that low levels of disciplinary enforcement are also the case in the UK. Of the 1600 complaints made to the General Medical Council in 1993 ten per cent made it through the initial screening process to the Preliminary Proceedings Committee, three and a half per cent were referred on to the Professional Conduct Committee and only six doctors were struck off the register (BBC Radio 4, 1994b). Of course this might reflect the outstanding integrity of British doctors.

No doubt high on the ‘Index of Visibility’ these days would be the issue of sexual misconduct. Of the 145,000 doctors in Britain in 1991, only two (i.e. 0.0014 per cent) were found guilty of ‘serious professional misconduct’ by the General Medical Council on such grounds: “... Either the pressure of work is having a disastrous effect on the British medic’s libido or there is some ‘under-reporting’ going on” (Gwyther, 1992:70). (See also Chapter 13.)

It follows from Carlin’s ‘Index of Visibility’ that, however much they may have cultivated media coverage of malpractice prior to licensing, once established, professions are unlikely to take steps to actively expose it in their midst. Activating disciplinary procedures is likely to generate publicity and court adverse public attention. Hence unless a case is already receiving adverse publicity, the temptation will be to ‘let sleeping dogs

lie'. Moreover active disciplinary monitoring is costly and time consuming. The profession's tendency will be to give priority to maintaining an impression that, because of the rigorous entry requirements, malpractice is a rarity rather than a position such as: 'well yes, it does happen a fair bit but we deal with it.' The latter is a second best policy in terms of the profession's image, status and degree of public confidence. This follows from professional control of, or dominant influence upon, the disciplinary process. If the disciplinary process were to be independent and well funded these arguments would not necessarily apply, but it rarely is. The specialized and elaborate knowledge base that typifies a recognized profession also provides the basis for the contention that only the professionals can really be in a position to judge their peers.

UKCP's disciplinary system is based on explicit codes of ethics and practice which are promulgated for each member organization. Disciplinary procedures currently operate at the level of the member organization through which the practitioner is registered (usually the one where they trained), with appeal to the section on the grounds of 'improper procedure'. Apparently, if the register were statutory, complaints would go directly to a disciplinary committee of the register, leading to a much more centralized system (see Chapter 6). Given the poor track record of systems based on professional codes of ethics and conduct and self-disciplinary action as a means of protecting the public, what reason do we have to be confident that such a system, given statutory approval, would be any more effective in producing its purported benefits for the public? Why should we not believe that it will largely function as window dressing disguising professional self-interest as has so often been the case?

Preventing unlicensed practice or title usage - curbing the charlatan

In terms of enforcement it does seem that licensing agencies are more zealous in prosecuting unlicensed practitioners than disciplining those with a licence.... (Hogan, Vol. 1, 1979:263)

However, according to Rayack (1975) this enforcement is generally in response to complaints from those with a licence, i.e. practitioners rather than consumers, and these complaints increase when the economic situa-

tion has deteriorated: "... When enforcement does occur, it is frequently aimed at curbing economic competition, not dangerous practices ..." (Hogan, Summer 1979:2). This is hardly in the public interest.

Enforcement of legislative powers with regard to unlicensed title usage or practice is expensive and consequently such powers may lie idle on the statute book until such time as the profession feels itself to be under sufficient economic threat to warrant the cost and trouble to enforce them. (See for example the situation in Australia described in Appendix B.)

In the light of all this, the conclusions of Jeffrey Pfeffer regarding the efficacy of statutory regulation should come as no surprise:

It must be concluded that the outcomes of regulation and licensing are frequently not in the interests of the consumers or the general public. It is difficult to find a single empirical study of regulatory effects that does not arrive at essentially this conclusion....

In a review of the outcome of regulation and licensing, we have found that the effect is almost always to enhance the position of the industry or licensed occupation at the expense of the public at large....

In view of these empirical results, accumulated in a series of studies covering both different time periods and different industries, the role of administrative regulation in the solution of social problems must be called into question. There is evidence that administrative regulation and licensing has actually operated against the public interest; and that rather than protecting the public from the industry, regulation has frequently operated to protect and economically enhance the industry or occupation.... Even if quality differences are observed, the question remains as to whether they are worth the cost. (Pfeffer, 1974:474,478)

The discussion in this chapter has set aside the issue of whether or not a sound case can be made for the public actually needing special protection from the occupation in question. This issue regarding psychotherapy will be addressed in later chapters.

Chapter 10

Licensing and the Public Interest - the Harmful Side-effects

... With respect to input regulations, a general licensure regime [for mental health services] seems highly undesirable. Social costs in terms of higher fees for services, reduced innovation, and undue interference with freedom of choice in highly subjective areas of personal values, are likely to be substantial...

(Michael J. Trebilcock and Jeffrey Shaul, 1982:289)

Hogan (Vol. 1, 1979) concludes that systems of licensing have various negative side-effects that need to be offset against any possible benefits such systems may bring and that: "... ***the harmful side-effects of licensing laws usually outweigh their supposed benefits ...***" (ibid.:238). He cites licensing laws as a significant factor in:

- (1) unnecessarily restricting the supply of practitioners [by introducing monopolistic factors into the market];
- (2) decreasing their geographic mobility;
- (3) inflating the cost of services;
- (4) making it difficult for paraprofessionals to perform effectively;
- (5) stifling innovations in the education and training of practitioners and in the organization and utilization of services; and
- (6) discriminating against minorities, women, the poor, and the aged [by raising entry requirements in terms of time, cost and academic prerequisites]. (ibid.:238-9)

Hogan clarifies how these negative side-effects operate as follows:

In addition to not protecting the public, licensing tends to have negative side-effects. First, higher than necessary and irrelevant

entry requirements restrict the number of persons able to enter the professions, exacerbating shortages in the supply of personnel. Second, through making it unnecessarily difficult for professionals licensed in one state to be licensed in another, licensing aggravates problems in the geographical distribution of practitioners. Third, broad definitions of practice, overly restrictive regulation of paraprofessionals, and the absence of alternative routes to licensure have decreased the overall supply of services unnecessarily. These three problems produce a fourth, which is a significant increase in the cost of professional services. Fifth, licensing inhibits important innovations in professional practice, training, education, and the organization of services. It does so through disciplinary provisions and ethical standards that create difficulties in advertising services and restricting how services may be delivered, through reliance on accreditation agencies whose criteria are not based on whether schools or programs produce competent practitioners and through defining quality in terms of what is currently acceptable by the majority of practitioners, not empirical evidence of effectiveness. Finally, reliance on academic degrees or other irrelevant or unnecessary entrance requirements, results in serious discrimination against minorities, women, the aged, and the poor. (Hogan, Summer 1979:2)

Furthermore:

... licensing laws, as currently conceived, tend to promote unnecessary and harmful consumer dependence, since their implicit philosophy is that the public is incapable of making use of information to decide on practitioner competence. (Hogan, Vol. 1, 1979:239)

Writing in 1993, Alberding et al. indicate that these conclusions have not been superseded by later studies or changes in the pattern of licensing:

Some counseling professionals view legislated regulation with a wary eye and are concerned that it will result in unintended and

undesirable consequences for both the profession and the public. In addition, economists, sociologists, and political scientists have long observed that there are costs inherent in occupational regulation. These potential liabilities include (a) increased consumer vulnerability, because regulation does not, in fact, protect the public as it promises to do (Gross, 1978); Hogan, 1979); (b) discrimination against some competent practitioners (Hogan, 1980); increased costs of services (Collins, 1979; Meltzer, 1975; Rottenberg, 1980); (d) loss of public power and control (Reiff, 1974); and (e) professional stagnation (Danish & Smyer, 1981; Rogers, 1973)....

... that costs increase following legislated regulation is an economic fact (Collins, 1979; Rottenberg, 1980).... In addition, the problems of discrimination, public loss of power and control, and the lulling of consumers into an unwary and vulnerable state are facts of life to political scientists, economists, and sociologists.... (Alberding et al., 1993:34-37)

The negative side-effects of licensing, which can be seen as the outcome of policies pursued by professional organizations who have control of the accreditation process (Hogan, Vol. 1, 1979:330), must be offset against the purported benefits of licensing, which are invariably argued for by those same organizations in terms of protecting the public from harm, although as discussed in the last chapter that has not been a proven consequence of such laws:

While it is true that the public needs protection from quacks, it also needs protection from the harmful side-effects of licensing.... ***the preferred policy is to protect the public from harm in general***, whether or not incurred by a practitioner. Such a policy requires an examination and weighing of the unintended and potentially deleterious side-effects of licensing. (Hogan, Vol. 1, 1979:239)

This is a very 'holistic' position that takes into account the *overall balance of risk and benefit to the public rather than focusing on particular issues of risk in isolation*.

Chapter 11

Licensing and the Public Interest - Pre-conditions for Licensing

... It is important to underscore at the outset the obvious but often neglected truth that even following the identification of imperfections or failures that would be likely to persist or develop in a market, if unregulated, the decision as to whether to regulate at all, and if so, in what way, presents special difficulties because all of the available regulatory instruments are also imperfect. Thus, the policy maker is faced by a daunting calculus that involves comparing the outcome from a flawed market with the outcome of flawed regulatory instruments. One imperfect state of the world must be compared with another....

(Michael J. Trebilcock, 1982:83)

These weaknesses of an occupational licensing system are formidable and suggest that licensure should be reserved for professional markets characterized by high costs of error by providers, high information costs faced by consumers, and/or substantial and widespread negative third party effects not fully compensable in damages, and for situations where there is a reasonably high correlation between prescribed training inputs and desired service outputs.

(ibid.:99)

Hogan comes to the conclusion that laws that restrict a person's right to pursue an occupation, whether by control of title or restriction of the right to practise should *not* be enacted unless the following *pre-conditions for licensing* are met:

(a) The profession or occupation being regulated must be mature and well established.

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The fact that a profession is dominated by one professional association and has highly uniform standards of practice is not necessarily a sign that such a profession is mature. ***The critical factor is whether agreement on uniform standards of practice is warranted by the empirical research.*** (Hogan, Vol. 1, 1979:366)

(b) The profession being regulated must have a clearly defined field of practice adequately differentiated from other professions.

(c) The profession must have a significant degree of public impact.

(d) The benefits of licensing must outweigh the negative side effects cited above. (That is, increased cost of services, lack of availability of professional help, inhibitory effect on the organization of services and discriminatory impact.)

(e) Simpler and less restrictive methods that would accomplish the same purposes must be unavailable (for example existing laws).

(f) The potential for significant harm from incompetent or unethical practitioners must exist and must be extremely well documented.

... Until recently, legislatures have been more than willing to pass licensing laws, as long as some possibility of harm could be demonstrated. Since virtually all occupations involve some danger, this does not provide a very good guideline.

Since it is generally the profession that is seeking licensure, and since there is a good reason to believe that economic self-interest may be involved, it should be incumbent upon the profession to demonstrate that licensure is actually necessary. This means that the dangers involved without licensure should be easily recognizable and not based on tenuous or remote argument. It means that both the magnitude and the probability of harm should be reasonably large. Isolated instances of severe harm should not constitute sufficient grounds for licensure.... (Hogan, Vol. 1, 1979:367)

(g) Practitioner incompetence must be shown to be the source of harm.

A reasonable consensus must exist as to what causes harm and the causes of harm must be related to professional functioning.... If no consensus exists as to what causes harm then it is unlikely that licensure laws will mitigate the dangers involved. If the causes of harm are related to environmental or client factors, then professional regulation will likewise have little impact.... (Hogan, Vol. 1, 1979:367)

(h) The purpose of licensing laws must be the prevention of harm.

Where licensing laws require certain standards to be met, these standards must be related to the prevention of harm.... It is not meant to ensure high quality professional practice. The efforts by various professional associations to require high standards of practice should be restricted because of the negative side effects inevitably engendered. (Hogan, Vol. 1, 1979:367)

(i) Adequate enforcement mechanisms for disciplining those who violate the law must exist.

(j) Adequate financial resources must be committed to ensure proper administration and enforcement of the licensing laws.

... If a legislature truly believes that licensing is necessary to protect the public, then it should budget an adequate amount of funds to do the job properly. (Hogan, Vol. 1, 1979:368)

Even when these pre-conditions are met, the type of licensing advocated by Hogan is, as we shall see, not one of the types that commonly prevail.

In the following chapters I will offer an assessment of ‘psychotherapy’ in the light of these pre-conditions, focusing on the most important issues raised.

Chapter 12

Licensing and Psychotherapy - Definitions and Boundaries

[Psychotherapy] is an unidentified technique applied to unspecified problems with unpredictable outcomes. For this technique we recommend rigorous training.

(V. C. Raimy, 1950:93)

The earliest use of the term psychotherapy was by J. C. Reil in 1803 in an article entitled “Rhapsodies in the Application of Psychic Methods in the Treatment of Mental Disturbances”. Since then the term psychotherapy has become a lexicographer’s nightmare. Definitions abound, though few have much in common with each other and many are antithetical.

(Daniel Hogan, Vol. 1, 1979:12)

... psychotherapy ranges from its conventional and established centre to obscure and quasi-religious fringes. Despite aspirations to acceptance and respectability, psychotherapy as a whole does not yet present the public with the unity and ideological coherence that are the hallmarks of a profession.

(Jeremy Holmes and Richard Lindley, 1989:204)

... Trouble is, psychotherapy is probably a whole bunch of different things that don’t fit under any one obvious umbrella....

(David Kalisch, 1990:26)

This chapter addresses preconditions for licensing *(a) the profession or occupation being regulated must be mature and well established* and *(b) the profession being regulated must have a clearly defined area of practice adequately differentiated from other professions.*

Psychotherapy does not meet these preconditions. It is not ‘mature’

and does not have a clearly defined area of practice which is capable of legal definition. Some see it as a medical matter, others see it as an educational process, others as something more akin to a spiritual developmental process. Is one suffering from mental illness if one is a candidate for psychotherapy or is one developing one's potential? Is one restoring normal functioning, "transforming ... hysterical misery into common unhappiness" (Freud, 1893-5:393), or actualizing potential? What degree of developed potential constitutes normality? Is it about helping people to adjust to the prevailing notion of what is 'normal' or helping people to actualize themselves even if that means they become less 'normal'? (See Section II.)

Is psychotherapy a form of medical therapy - a treatment? Is it 'the talking cure'? The Foster and Sieghart Reports lean in that direction, the former seeing it as: "the practice of psychological medicine" and the latter as: "this field of medicine" (see Chapter 5) and the contents of some UKCP documents indicate that 'medicalized' language and thinking is alive and well in that organization (see Chapter 23). Some of those involved in UKCP, even in the Humanistic and Integrative Psychotherapy Section, are explicit about the appropriateness of a medical model of psychotherapy. Petrůska Clarkson, for example, regards psychotherapy as an activity which is best seen as focusing on 'revolutionary change', that is, diagnosis of pathology and a deconstructing and restructuring of the personality:

Psychotherapy, on the other hand [compared with a focus on evolutionary change in counselling], focuses on discontinuous, revolutionary change. The justification for psychotherapy often needs to be that such an expensive and time consuming intervention is necessitated because, unless discontinuous change is implemented, serious tragedy may result. In this case the medical model may be appropriate in terms of diagnosis (or at least assessment) leading to treatment implementing or seeking for a 'cure'. A medical model may be more effective when there is actual structural damage to the organism which has to be reversed before the organism can start reconnecting with its own innate healing process. Psychotherapy, whether psychodynamic, behavioural or humanistic/existential, concerns the deconstructing and restructuring of the personality, whether it is conceived of as

belief-and-behaviour systems, ego states, or super-ego and self structures. (Clarkson, 1994:10)

The term ‘psychotherapy’ is itself medical model terminology (see Chapter 24). Psychotherapy and the medical profession have a long historical association, the more so in North America where, in the first half of the century at least, psychoanalysis was the epitome of psychotherapy and US psychoanalytic organizations were opposed to the training of ‘lay’ analysts - those without medical qualifications. In the post-war era, other models besides a medical one have established themselves in ‘psychotherapy’ however the medical model still rubs shoulders with them, and it has big shoulders! (See Chapter 25.)¹

How is psychotherapy different from counselling? What are the boundaries? What are the distinctions? ‘Counselling’ used to be a perfectly serviceable word referring to the act of giving advice or guidance. Nowadays, many counsellors are more likely to eschew the act of giving counsel and regard this as a common misapprehension of their nature of their job (Bennett, C., 1994). According to Feltham and Dryden: “[The term ‘counselling’] has a variety of meanings (and many of them are problematic)...” and: “... In the opinion of most mainstream personal counsellors, such usage [as ‘debt counsellor’, ‘beauty counsellor’ etc.] is incorrect and/or unfortunate ...” (Feltham & Dryden, 1993:40-2).

This ‘counselling’, shorn of any advisory connotations, has its roots in the USA with Carl Rogers and, before him, the radical social activist Frank Parsons (Bond, 1993:17). Brammer and Shostrum (1982) have attempted to identify the characteristics that distinguish ‘counselling’ from ‘psychotherapy’ in an American context. According to their study of the American literature, counselling is seen as being an educational process of relatively short duration concerned with solving problems that arise primarily from situational pressures rather than from severe or persistent emotional difficulties. The focus is on present time and conscious awareness. Psychotherapy, by contrast, is seen as an analytic and reconstructive process of longer duration that is more concerned with issues arising from within the personality than from the person’s situation and one which works with ‘neurotics’ or those with severe or persistent emotional problems. The focus is more on preconscious and unconscious processes and events

in the patient's past than is the case with counselling (Bond, 1993:25).

In an effort to define the differences from a UK perspective, Tantam and Rickard compared counselling and psychotherapy in relation to twelve possible distinguishing criteria and could find no obvious and clear distinctions except perhaps that psychotherapy is more associated with the treatment of mental illness or personality disorder and has perhaps a higher status due to a historical association with medicine, and that counsellors tend to have more eclectic backgrounds than psychotherapists. They suggested that the relationship between general practice and psychiatry might provide a model for how to draw a boundary between the two. However, they commenced their article with the statement that: "Neither counselling nor psychotherapy are clearly defined activities. Distinguishing between them is therefore particularly difficult. Indeed there are many counsellors who consider that they cannot be distinguished in practice, although the fact is that they continue to call their work 'counselling' rather than 'psychotherapy' ..." (Tantam & Rickard, 1992).

As mentioned above, Clarkson (1994:9-11) thinks counselling and psychotherapy are best distinguished by highlighting what she sees as their polar opposites - a focus on evolutionary or revolutionary change respectively, rather than trying to make a boundary where clearly there is at least a considerable degree of overlap. However, that will not do for legal purposes unless the 'circularity' gambit is applied (see below).

Rowan (1983:9) argues that an important distinction between counselling and psychotherapy in practice is the length of the training. Although training programmes in both cases are tending to get longer and longer it does often seem to be the case that those organizations which offer training in both counselling and psychotherapy are liable to require a longer training for the latter and to regard its status as 'higher'. However, length of training does not appear to relate to basic competence in this sort of field (see Chapter 16) and therefore even if this does constitute a general difference it does not necessarily constitute a functional distinction.

In the case of the term 'counselling' we have a word that once meant something fairly clear but which has become yet another ambiguous generic overlapping the ambiguous use of the term 'psychotherapy'. As we have seen in Chapter 7, the British Association of Counselling does not believe that a generally accepted distinction between counselling and psy-

chotherapy can be made. According to Judith Baron, general manager of the BAC: "It's increasingly difficult to define where the boundary line is, even if there *is* one" (Bennett, C., 1994). Brian Thorne concurs and suggests that the quest for the difference between the two is illogical and invalid (Thorne, 1992). Tim Bond suspects that the differences may have more to do with status and money than with anything more substantial: "... I am frequently told that in private practice the label 'psychotherapy' attracts higher fees from clients than 'counsellor' ..." (Bond, 1993:26). (For further discussion of 'counselling' see Chapter 26.)²

Is psychotherapy a form of 'psychological practice' and therefore a psychotherapist a type of psychologist? This is often taken to be the case in other countries where the practice of psychotherapy is often regulated by psychology boards (see Appendices B and C). The British Psychological Society has referred to psychotherapy as 'psychological therapy' and is also designing a qualification in 'counselling psychology' (see Chapter 7 and Feltham & Dryden, 1993:42). Then there is the question of 'psychological counselling' not to mention 'therapeutic counselling' ... !

Is the term 'therapist' a shorthand for 'psychotherapist' or does it mean something different? Some people imply it is a lowlier title (e.g. Young, 1990 quoted in Chapter 8). The Association for Humanistic Psychology Practitioners 'category guide' to humanistic psychology practice (AHPP, 1993) refers to both 'psychotherapists' and 'therapists' of various types and appears to indicate that AHPP regard 'psychotherapists' as more competent to work with: "people with complex problems over a long period of time" (ibid.).

It is often suggested that psychotherapists are more *au fait* with transference and countertransference than mere 'therapists' or 'counsellors'.

What distinguishes a psychotherapist from, say, a spiritual teacher? Can psychotherapy be a compulsory treatment e.g. for involuntary mental hospital patients or for sex offenders in prison or can it, by its very nature, only be a voluntary endeavour? Is it an art, a craft or a science?

As Parloff says: "Psychotherapy cannot be defined either by evidence of its unique effects or by its professionally specialized and restricted techniques" (Parloff, 1970:295). Psychotherapy is *not* a unified field. There is not a consensus as to values, goals and means amongst the activities that are referred to by this label. There are instead different underlying models,

with differing goals and values, vying for predominance. (See Section II.)

The agreement amongst those in UKCP does not so much reflect the evolution of a coherent profession but rather an agreement to stick together in the pursuit of power. It is a political alliance.

Statements commenting on the impossibility of defining the term ‘psychotherapy’, *especially for legal purposes*, are legion:

No problem in licensing has proven to be a greater bone of contention than the matter of psychotherapy. Although everyone has his [or her] own private opinion of what psychotherapy is, no one has yet come forward with a definition of psychotherapy sufficiently precise to stand in a court of law. (Combs, 1953:562)

It is also evident that the profession of psychotherapy cannot yet be adequately defined and has not yet differentiated itself sufficiently from other professions. Whether defined by goals, methods, structure, or theoretical base, psychotherapy is impossible to clearly delimit, ***except through arbitrary determinations***. A committee of the American Medical Association (Gerty, Holloway, & MacKay, 1952), for instance, concluded that “after a great deal of discussion ... psychotherapy could not be defined satisfactorily, at least for legal purposes, though persons and groups, both medical and non-medical, often put forward definitions which suit their own purposes....

The problems involved in defining psychotherapy and their implications for regulation were recognized by organizations such as the American Psychological Association when it originally began to seek legislation. The passage of time, however, has seen the APA and others ignore these implications. It has become apparent that political considerations of power and control have outstripped concerns about the value and quality of regulation.... (Hogan, Vol. 1, 1979:368-9)

How can a professional group regulate an activity it is unable to define ... ? The answer, obviously is that it cannot. (Leifer, 1969:155)

But of course that won't stop them trying. As mentioned in Chapter 6, an approach that has been employed where a professional group has succeeded in getting psychotherapy subject to some form of statutory regulation is not to define 'psychotherapy' (or 'psychology') in the legislation in any functional terms at all and to leave wide discretionary power with the registration board which it can then exercise during times of economic recession or whenever suits the profession. Associated with this, a legal definition can be achieved by a circular means. A 'psychotherapist' or a 'psychologist' can be defined *as someone who is on the register*. So, once the register is established and power has been achieved, the problem of meaningful definition and functional boundaries can be avoided altogether. Clarkson (1994) has raised this as a possibility for UKCP:

... There is no agreement on the exact boundaries of psychotherapy. One result of this is that the political definition of psychotherapy has given rise to great arguments and considerable tensions in the profession.... It is possible to define psychotherapy as all those therapies that are recognized by the UKCP. That is a simple way of reaching some sort of agreement. The trouble is that there are always some who claim that some psychotherapy is excluded from the Council. This is merely another way of having the argument of what is, and what is not, psychotherapy. On the other hand we can recognize that other professions also have ill-defined borders [which?], and we can stop worrying so much about our general definition or our political solution by recognizing that the borders of psychotherapy are not fixed. (ibid.:4)

Such a solution would be very convenient for UKCP and might alleviate worries for those within that organization but would be unlikely to be beneficial for the stress levels of those outside it.

Another approach is to define the area of practice in as broad a fashion as possible, a 'catch all' definition as lampooned by Raimy in the quote at the beginning of this chapter. As Hogan says, many of these definitions are: "so broad that it is difficult to know what is not within their purview" (Hogan, Vol. 1, 1979:248). When the Ontario Psychological Association proposed the establishment of a practice act in that Canadian

province, a major public controversy ensued given that the proposed field of psychology was defined so broadly that objectors felt it covered functions performed by almost every citizen at some time or another as well as overlapping such areas as teaching, business, personal development, art, religion, etc. It was argued that it would be dangerous to allow the Ontario Psychological Association a monopoly on what values could be permitted in society. In the province of British Columbia however, similar legislation was passed before objectors (including the BC Civil Liberties Association) were sufficiently aware of it to organize opposition (Trebilcock & Shaul, 1982:286-8). (For details of subsequent legislation in Ontario and British Columbia see Appendix C.)

UKCP has yet to offer a definition of psychotherapy in its publications. However, the activities of the Lead Body for Advice Guidance and Counselling, including its 'functional analysis' of psychotherapy, along with competition from the BAC's notion of 'therapeutic counselling' indicate that this silence on the matter is unlikely to last. (See Chapter 19.)

Thus 'psychotherapy' is a term that is difficult to define in a meaningful way that covers all the activities for which it has been used. Psychotherapy, psychology, counselling, human potential practice are all things that are concerned in some way or other with something as close to home as it gets - with our experience of ourselves and the world, with our subjectivity. Trying to define such a thing 'objectively' for legal purposes is deeply problematic. Discussions such as whether 'psychotherapy' should be a regulated profession (and this discussion is no exception) are stymied by the difficulty of knowing quite what is being referred to by the term and the tendency to try to fit disparate activities under one generic umbrella - a tendency driven more by political considerations than functional ones. In Section II, I will attempt to make some functional distinctions between types of work in this area on the basis both of the question 'what?' and the question 'for whom?' since in this area in particular 'for whom?' feeds back and changes the nature of 'what?' A differentiation on the basis of the values and intentions of the people concerned and on the basis of the type of person receiving the service and *their* status is, I think, helpful and clarifying - whatever the label by which those forms of work may be currently referred to.

Chapter 13

Licensing and Psychotherapy - Protecting the Public from Harm

In a human relationship, just when is a person harmed? How can you prove it? These are difficult questions to answer for the plain fact of the matter is that people are helped by the damnedest things. Almost anything may help people to behave more effectively or to feel happier given the right circumstances. Who is to say that a particular idea taught to a client was an act of quackery, especially if the client swears it was helpful? Much of the business of human relations is carried on through no more than what one person says to another. It is doubtful if we shall ever seriously want to control such intercourse in a free, democratic society. The cure could well prove more fatal than the disease.

(Combs, 1953:558)

This chapter addresses preconditions for licensing *(f) the potential for significant harm from incompetent or unethical practitioners must exist and must be extremely well documented, (g) practitioner incompetence must be shown to be the source of harm and (e) simpler and less restrictive methods that would accomplish the same purposes must be unavailable.*

Safeguarding the public from harm is the key argument upon which any claim for the legitimacy of a licensing system must rest. It is the most cited rationale for such a system and, as we have seen, UKCP is amongst those organizations that have claimed protection of the public as a main aim. As Daniel Hogan puts the matter:

Central to the problem of regulating psychotherapists is the degree of risk and danger involved in the psychotherapeutic process. The demand for regulation rests largely on this alleged danger, and the constitutionality of many licensing laws hinges on an

adequate demonstration of significant risk. (Hogan, Vol. 1, 1979:25)

What then is the scale of the problem? To give perspective during the course of this discussion, it is useful to bear in mind the dangers of addiction and other side-effects which have frequently accompanied the application of “chemical solutions to personal problems” (Pilgrim, 1990:6). Despite both drug and medical licensing systems, there is usually little hope of redress for such damaging effects in this country other than through the courts on a collective basis (see Appendix E).

Determining the degree of danger is more complex than first appears. The seemingly simple task of defining what constitutes an adverse result is in fact very difficult. Determining whether psychotherapy is responsible for precipitating suicide or severe emotional distress is not an easy matter. Subtler still is the question of the duration of emotional injury since negative effects may only be transitory. ***Often ignored is the necessity of comparing the level of danger in psychotherapy with that in other activities for which no demand for regulation exists....*** (Hogan, Vol. 1, 1979:25)

Various aspects of this issue can be outlined. What constitutes harm? (and what simply relapse ?) What evidence is there of a significant risk of harm, and for whom? What evidence is there that, where a significant risk can be demonstrated, it is a consequence of practitioner incompetence? How does the risk of harm compare with activities for which no demand is made for regulation? (After all, few worthwhile activities in life do not involve *some* element of risk.) How does the degree of harm which may occur compare with the harm deriving from the institution of a licensing system intended to ameliorate it? Can simpler and less restrictive methods such as the application of existing laws accomplish the same purpose?

Thus there are rather considerable conceptual difficulties here that parallel those concerning the definition of psychotherapy. What constitutes recovery or improvement - and what constitutes deterioration - depends on how psychotherapy is conceived. For example, in discussing the

proposition that all therapies aim to make the client feel better, Kline has this to say:

This argument makes several assumptions about the nature of psychotherapy and of human life itself (the latter topic almost certainly out of bounds in respectable academic psychology!). Thus I see no necessary reason why a client should be happy. As Freud (1923) put it, the aim of psychoanalytic therapy is to make neurotic unhappiness into normal unhappiness. It seems to me a quite respectable argument, as Smail (1984) has eloquently shown, to admit that the lives of many people are unhappy and that to assert otherwise or to attempt to persuade clients that there is something wrong with them because they are unhappy, is distasteful and ultimately propping up a society that is better changed. With such a view, the aim of psychotherapy becomes one of helping clients to accept their feelings. In fact political rather than psychological change is implied in such a viewpoint.

It is not my intention here to support or attack any of these notions concerning the nature of psychotherapy, psychoanalytic, behavioural or, for want of a better term, political. My point is simply that implicit within the aims of psychotherapy and consequent outcome measures lie such fundamental viewpoints or values. The problem, from the standpoint of research into psychotherapy, is that research results are unlikely to be relevant to all these views.... (Kline, 1992:74)

According to Stanislav Grof:

Since the criteria of mental health are unclear, psychiatric labels are problematic, and since there is no agreement as to what constitutes effective treatment, one should not expect much clarity in assessing therapeutic results. In everyday clinical practice, the measure of the patient's condition is the nature and intensity of the presenting symptoms. Intensification of symptoms is referred to as a worsening of the clinical condition, and alleviation is called improvement.... (Grof, 1985:330)

Such a perspective is at variance with Grof's own view that the intensity of what are regarded as symptoms under the medical model is actually an indication that a healing and transformative process is at work:

... The therapeutic philosophy based primarily on evaluation of symptoms is also in sharp conflict with the view presented in this book [*Beyond the Brain*], according to which an intensity of symptoms indicates the activity of the healing process, and symptoms represent an opportunity as much as they are a problem. (ibid.)

Moreover, culture-bound, 'social adjustment' criteria may also be used as a basis for assessing therapeutic results in addition to, or as part of, the assessment of symptomatology. For example the diagnostic criteria for 'personality disorders' in DSM-IV (see Chapter 20) specify that such 'disorders' are: "An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture" (American Psychiatric Association, 1994:275). From other perspectives, such a 'deviation' *may* indicate a heightened personal integrity, 'resistance to being rubricized' and above average 'sanity' (Hampden-Turner, 1970; Maslow, 1968).

In practice, most outcome studies of psychotherapy do seem to assume a medical model involving the diagnosis and treatment of psychopathology (or at the very least a problem-solving model).¹ Presumably without making this sort of assumption it would be rather difficult to even begin to do such research. (Have there been any 'outcome' studies of spiritual disciplines or religions? Which religions are the most efficacious?)

According to Isla Lonie: "... Morstyn [1989] has listed the assumptions which he believes underpin much of the current thinking in psychotherapy research: (a) That everything has a defined nature. (b) That events are fully predictable and determined. (c) That an event can be considered separately from the agent of that event ..." (Lonie, 1991b:552). Lonie adds a further concept: "... (d) That in a discipline which emphasizes the importance of the unique experience of the individual, it is possible to understand events in terms of statistical probabilities" (ibid.). These are essentially Newtonian-Cartesian paradigm assumptions applied to human beings -

and ones which imply an image of them as part of a 'clockwork universe' running according to pre-established 'Laws of Nature'. Despite having been transcended by advances in our understanding of physics, the Newtonian-Cartesian paradigm still has useful applications in some areas of the physical sciences, offering reliable predictions - yes, that apple will fall on your head. However, its applicability becomes progressively less appropriate as one proceeds from the physical, through the biological to the personal and spiritual spheres, and such a deterministic view does not really fit very well at all with, say, a personal growth view of psychotherapy.

Kline (1992:65) argues that in addition to such issues of assumptive definition and meaning, the study of outcome in psychotherapy is plagued by numerous methodological problems that few if any studies have been able to overcome. For example well known psychological tests (such as the MMPI²) which are often used to measure recovery (or deterioration) are of dubious validity. Bearing all these strictures in mind, I will explore the empirical research available, such as it is.

In a 1988 survey of research into hurtful psychotherapy, Striano cites Bergin's well known studies of the 'deterioration effect' which appear to show that ten per cent of clients in psychotherapy (with licensed practitioners presumably, since this is US research) deteriorate, which is five per cent more than for his control group who received no psychotherapy. So, on the basis of this study five per cent of the clients were worse off than if they had received no therapy - which seems to be about average for the studies surveyed (Striano, 1988:121).

Turning now to the area of humanistic psychology practice, in the 1960s and 1970s the burgeoning of encounter and similar groups lead to numerous anecdotal reports of dangers and subsequent empirical studies. Regarding anecdotal reports of the risks of harm involved in encounter groups, Hogan reports that:

... The number of cases described in the encounter field is sufficiently large, and enough of these are thoroughly documented, to warrant the conclusion that encounter groups can and do cause harm in certain instances. The frequency with which harm occurs, however, remains open to question. Unfortunately the ten-

gency has been to use anecdotal reports as proof that encounter groups are so dangerous that rigid regulation is needed. ***Yet a similar array of horror stories could easily be assembled about highly credentialed psychiatrists and psychologists, all of them licensed.*** (Hogan, Vol. 1, 1979:65)

Referring to empirical research on encounter groups, Hogan states that:

When reviewers conduct a comprehensive analysis of outcome studies in the encounter field, they generally find little evidence of a high level of risk. Parloff (1970:289) was one of the first to comment on this fact.... he concluded: "The circumspect clinician who wishes to advise prospective group participants regarding possible dangers can, with confidence, offer only the following kind of advice: participation in most encounter groups is likely to be more dangerous than attending an office Christmas party and somewhat less dangerous than skiing...."

... Cooper(1972) ... argued that from his review of the literature the danger had definitely not been proved, and that some evidence existed that encounter groups were less stressful than university examinations.... (Hogan, Vol. 1, 1979:68)

The finding of a low rate of casualties is fairly uniform among those who have conducted an overall analysis of outcome studies in the encounter field.... [for example Easton, Carr, and Whiteley (1972) found that] most of the concrete evidence available indicates that casualties are comparatively rare and usually involve people with some previous history of psychological difficulty. (Hogan, Vol. 1, 1979:75)

... In fact one cannot help but be struck by the number of studies that have found encounter groups to pose only minimal dangers. (ibid.:69)

Thus encounter groups would seem to pose even less risk than conventional verbal psychotherapy.

Having surveyed the evidence available regarding the risks involved in both conventional verbal psychotherapy and encounter groups (as representative of the human potential movement) Hogan concluded that:

... psychotherapy, whether traditionally defined or including the newer encounter groups and humanistic therapies, does not appear to be gravely dangerous. This does not deny the existence of isolated instances of serious harm, but to suggest that overall the dangers may be overstated.

The percentage of people who deteriorate as a result of psychotherapy is somewhere around 5%, while the research on encounter groups generally reports figures of 1% or less. ***These dangers are not of such epidemic proportions that the arm of the law should intervene to curb the problem....*** (ibid.:370)

Thus, even though the bias of research is liable to favour a medical model (a model which I personally do not favour in this area), the evidence available does not appear to indicate that psychotherapy and personal growth work pose a particularly significant threat of harm to the public. Those who seek to justify the licensing of psychotherapy on this basis need to prove their case.

How much of the risk that psychotherapy does appear to pose is attributable to the practitioner - and attributable in a way that can be addressed by a licensing system?

As indicated in Chapter 5, the Sieghart Report cites with favour the opinions of the Royal College of Psychiatrists, the British Medical Association and Sir John Foster that psychotherapy can cause harm if carried out by 'unqualified' as opposed to 'qualified' practitioners, however the dissenting view of the behaviour therapists appended to the report refutes this view on the grounds of lack of evidence. Both points of view however beg the question as to what meaningfully counts as 'qualified' in this area.

Establishing causation is problematic. The case of supposed provocation of mental illness cited by Foster from the Anderson Report, which I quoted in Chapter 5, dramatically illustrates the perils of too readily jumping to conclusions as to causation. Lonie (1991a:122) has suggested that rather than a simple Newtonian 'billiard ball' model of cause and effect

which implies that the client is a passive recipient of the ‘effects’ of the psychotherapist, a more appropriate paradigm for looking at psychotherapy is that of ‘Chaos Theory’, in the light of which psychotherapy may be conceptualized as a non-linear system of mutually cueing feedback loops.

Furthermore, the application of general findings to a particular individual case is fraught with difficulty, the more so when, from one perspective at any rate, the essence of the psychotherapeutic activity is a focus on the individuality of the client. It is over-optimistic to suppose that individual outcomes are predictable. Such a view presumes that this sort of activity is more ‘scientific’ than it actually is. In discussing the difficulties of predicting which ‘patients’ are liable to be provoked into ‘breakdown’ through going into psychotherapy, Rowan (1983:12) cites the example of David Malan of the Tavistock Clinic who has this to say on the matter:

During many years at the Tavistock Clinic, I have accumulated a long list of patients in whom this question arises [relief versus increased disturbance]; and, even being wise after the event, I have found myself quite unable to distinguish between these two possibilities. I am constantly being surprised by patients whom I would not expect to break down who do break down, and those whom I would expect to break down, who don’t. This remains an area where systematic research is badly needed. (Malan, 1979)

Maybe so, but unfortunately one cannot do a ‘double-blind’ trial on a particular individual’s life for the purpose of a control study. Reincarnation aside, we each only have one shot.

Bergin’s studies of the ‘deterioration effect’ mentioned earlier, focused on ‘therapist-induced deterioration’ and Strupp refers to ‘negative effects’ to describe his findings which implicated the therapist as a factor in harmful psychotherapy, particularly ‘noxious personality traits’ of the psychotherapist, though also ‘deficiencies of technique’ (Striano, 1988:81,119). Mays and Franks: “... use the term ‘negative outcome’, which does not implicate the therapist in blame for the failure. Franks focuses on ‘patient characteristics and extratherapeutic events’ that may be responsible ...” (ibid.:119).

As will be discussed in Chapters 14 and 16, it does seem that the so-

called ‘non-specific factors’ (Lonie, 1991a:118) such as the personal qualities of the practitioner, for example empathy, the personal qualities of the client, for example motivation to change (rather than simply to satisfy dependencies or narcissistic needs) and a congruent match or helping alliance between practitioner and client are the sort of factors most strongly related to positive outcomes (Russell, 1981/1993). Presumably the absence of such factors also relates to negative outcomes, however such criteria are difficult ones on which to build a licensing system.

Hogan concludes that: “Assuming, however, that psychotherapy represents a significant public danger, the lack of consensus as to what causes danger and how to measure it should prevent the enactment of laws restricting a person’s right to practice.... factors quite apart from the practitioner such as the initial level of a patient’s mental health, may account for a large share of the harm that occurs in therapy” (Hogan, Vol. 1, 1979:370).

The question of harm for *whom* will be addressed in Chapter 17. The chapters in Section II are also highly relevant.

In the context of the push for registration by the UK therapy bureaucracies it has been claimed that: “While many people have been helped by therapy, there is increasing evidence that vulnerable, traumatized clients are being abused by badly trained therapists working without supervision or regulation...” (Pepinster, 1993). And, Dr. John Marzillier, chairman of the British Psychological Society’s Standing Committee on Psychotherapies is reported as claiming that statutory registration of psychotherapists will provide safeguards against unscrupulous, untrained and unmonitored individuals whose practices are “causing untold misery and damage to many hundreds or thousands of people” (Illman, 1993). Bear in mind here that the British Psychological Society is not an independent research body but rather should be viewed, in this context at least, as more like an academic psychologist’s trade association or guild, albeit one with a Royal Charter. (I wrote to Dr. Marzillier in September 1993 requesting supporting references for his statement but I did not receive a reply.)

Certainly the risks of therapy have increasingly become a subject of interest for the media (Bond, 1993:5) but has there been a recent flurry of substantial new evidence indicating a degree of risk greater than that outlined above? Has substantial evidence come to light showing that unlicensed practice bears a significantly greater degree of risk than licensed

practice? If so, I failed to find it.

It seems fair to assume that the number of people engaged in psychotherapy and related activities has grown over the last twenty years or so, and one would expect there also to be an increase in reported cases of harm, however this does not signify that psychotherapy is more risky than previous studies have indicated. Obviously, the amount of harm occurring needs to be compared with the volume of activity to give a meaningful assessment of risk.

Bond (1993:8) indicates that of the 9000 members of BAC only 0.25 per cent (23) have been involved in formal complaints (complaints that is, not ‘convictions’). One might argue that this low level of complaints is *because* of BAC - the type of practitioner and/or client that it attracts and the nature of counselling, rather than reflecting the generally low levels of risk for psychotherapy across the board, as indicated in previous studies. By the same token however, the case for the statutory regulation of counselling is weakened if a voluntary arrangement appears to work so well and is available to those clients who need such reassurance.

In the absence of reliable new evidence showing a significantly greater risk than that indicated by the research I have cited, such statements as Pepinster’s and Marzillier’s must be regarded as unsubstantiated. I am reminded of the situation regarding encounter and other such groups in the 1960s and 1970s mentioned above, where anecdotal scare stories evoked public curiosity, fear and media attention. As we have seen, the considerable body of empirical research that followed did not by and large bear out anecdotal reports of significant risk.

The current UK registration advocates do not appear to have built their edifice on the basis of sound empirical evidence of a high level of risk to the public. *Nor do they provide evidence to support their contention that any risk to the public can be best remedied by the schemes they propose.* Rather, they fall back on emotive statements of the “untold” variety as cited above. (I think we should be told!) Given the hidden agenda of professions and the wealth of evidence indicating that licensing systems (statutory regulation) often fail to protect the public in the way intended and have serious negative side-effects, such vague justifications should not be allowed to become the basis for licensing without adequate supporting evidence.

One may argue as does Rowan (1992b) that outcome research: “is perhaps about the weakest area in the whole field of psychological research” and that: “the best controlled studies tell us virtually nothing about psychotherapy as ordinarily practised” and that we therefore cannot take outcome research at face value. But then *nor can we take at face value the unsubstantiated arguments of licensing advocates, particularly when they speak for professional organizations who stand to gain from the restrictive practices thereby invoked.*

Much of the recent concern about the risks of harm in psychotherapy has focused on abuse of power in the therapy relationship. It is often argued that inherent inequalities of power between therapist and client, and transference wishes on the part of the latter, provide an open invitation for the abuse of power by the therapist and consequently a significant risk of harm for the client. (Note that if this is the case, it has not revealed itself in the empirical evidence cited above.) Aveline for example argues that:

The arena in which individual therapy takes place is constructed essentially by the therapist. Though subject to negotiation, the therapist decides the duration, frequency and form of the therapy. Ultimately, beginning and ending is in her hands, the latter being a powerful threat to the patient who is dependent or not coping. With rare exception, the meetings take place on the therapist’s territory. The therapist, whether trainee or trained, is held to be expert in what goes on in the arena, certainly by the patient, who is relatively a novice in this setting. What procedures the therapist propounds, the patient is predisposed to accept. Because the sessions take place in private, the therapy is not subject to the natural regulation of the scepticism and even incredulity of outsiders. All this gives therapists great power and, consequently, exposes them to great temptation. (Aveline, 1990:324-5)

Such an account presents a one sided view that only looks at the possible powers that may be abused by the practitioner rather than also addressing those that may be abused by the client. Furthermore it bristles with assumptions that may or may not apply in a particular type of work or a particular case. For example it seems predicated on assumptions of an

extremely passive and non self-directing client/patient and/or a setting such as where the 'patient' is assigned to a practitioner rather than choosing freely with whom to work. The practitioner's 'expertise' may give a power advantage if the model of work has an explicit or underlying treatment ethos, however if the model of work is more one of an adult to adult contract or a dialogue between equals (Dryden, 1990:274) then this power advantage cannot be assumed to be the case. Moreover in terms of encountering any particular client the practitioner is a relative novice. The client knows him/herself better than the practitioner ever will. In private practice even if the therapist decides the duration, frequency and form of therapy, the client has a choice of therapists and can choose a 'recipe' of such variables to suit their needs. In my experience more often than not it is the client who decides when to end. It is true that sessions are likely to take place in a space provided by the therapist, in private and often in the therapist's own home. This however also gives the client power which can make the therapist vulnerable to malicious acts, verbal abuse, intimidation and assault by clients and intrusion into privacy. Remember that strong feelings are often what is being dealt with and that the client has often come for that very purpose. Moreover whereas the therapist will usually feel bound by principles of confidentiality, the client is not usually so bound and may talk freely, making the therapist vulnerable to any one-sided or distorted accounts that may be put about, without the therapist usually being in a position to refute them. In the humanistic field, where simultaneous participation in individual and group work is commonplace, individual work may have a semi-public nature in that the client can refer to it in the group if so desired. Thus it is by no means inevitable that an unequal balance of power and potential for abuse lies in the practitioner's favour. Such a view assumes that the situation is seen through the lens of a medical model or some near relative thereof, whereas so much depends on the type of work and the type of client.

As regards the role of transference wishes in this, I will explore this in more detail in Chapter 17, suffice it to say here that transference reactions are also a source of vulnerability for the practitioner, depending on their nature. 'Negative' transference reactions on the part of the client may lead to various forms of destructive 'acting-out' including 'blaming' and 'accusations' that more appropriately have a historical focus. Moreover

those transference reactions that make the client more vulnerable to abuse are unlikely to be ameliorated by professionalization and statutory recognition - in fact they are more likely to be exacerbated thereby (see Chapter 17). Furthermore, as outlined in previous chapters, the potential for 'abuse' of the public as a whole by practitioners as a group would be enhanced by the actual social power so engendered.

With regard to the abuse of power, particular attention has centred on the question of sex between practitioners and clients/patients (both current and former). Such sexual activity has been regarded as inherently abusive in nature (by parallel with child sex abuse) and that a client/patient (especially a woman) is incapable of freely consenting to sexual activity with a practitioner (Austin, 1990:148; Rutter, 1989:25). Furthermore, under the laws of some states in the USA, such activity is a felony and in the case of the laws of Florida, for example, the psychologist-client relationship, and hence this incapacity to consent, is deemed to continue "in perpetuity" that is, for ever (Austin, 1990:145).

This issue of practitioner-client sex has also captured the attention of the media (as matters sexual have a way of doing) and has led to adverse comment about the 'unregulated' status of psychotherapy and 'alternative' practitioners.³ Moreover, the high profile of the issue has led to renewed nervousness about any form of physical contact between practitioners and clients after a few decades in which there has been: "... an increasing acceptance of physical and emotional intimacy between psychotherapists and their patients under the guise [*sic*] of humanistic approaches to psychotherapy ..." (Garrett, 1994:431).

At the 1993 annual conference of the British Psychological Society, new empirical research was presented that revealed that of a group of 580 clinical psychologists studied, four per cent admitted to having had sex with their patients. These findings were used as a basis for the Society's bid for statutory regulation of 'psychologists', even though all of the practitioners cited were already members of BPS (Hall, C., 1993; Garret, 1994).⁴

For the purpose of this particular discussion the key thing to note is that practitioner-client sex occurs in professions that are *already* licensed and have specific sanctions against it. Furthermore, as far as I know, there is no clear evidence to that its incidence differs between licensed and unlicensed settings (Garrett, 1994:432). Rutter (1989:35) cites six to ten per

cent of psychiatrists as having had sexual contact with a patient. Kardener et al. (1973) carried out an anonymous random survey of Californian psychiatrists in which five to ten per cent self-reported having had some kind of erotic contact with patients, while five per cent reported having intercourse. A more recent survey in the USA reached the similar conclusion that nine per cent of medical doctors have had some form of sexual contact with their patients at least once in their careers (Gwyther, 1992:70). So this issue, whatever its consequences, is not in itself a sound argument for traditional forms of licensing as is often maintained.

Moreover, the cases of abuse in therapy referred to by Masson (1988, 1992) mainly involved practitioners who were *already* licensed professionals (i.e. medical doctors, clinical psychologists) and their resulting status in community if anything made it *harder* to challenge their abuses.

As Nick Totton says: "... Looking at the highly regulated medical profession, we find much the same problem - a handful of abusers. It doesn't happen often, but it does happen whatever the controls. We would need to look much deeper into the structure of our society in order to defeat this sort of abuse. Curiously though, if psychotherapists ever do abuse their role, they are in some ways more open to retribution than members of high-status professions such as medicine and law. The latter are protected by the closing of ranks, by self-policing systems and by a general belief in their semi-godhood. Furthermore, an independent therapist who isn't very good is far more likely than a doctor or lawyer to stop getting clients" (Totton, 1992:26).

In sum, as Carl Rogers has said: "There are as many certified charlatans and exploiters of people as there are uncertified" (Rogers, 1973).

Even if psychotherapy did pose a more significant and widespread risk of harm to the public than appears to be the case, in view of the harmful side effects outlined in Chapter 10, licensing (statutory registration) as a remedy would still not be justified unless simpler, less deleterious methods to accomplish the same purpose were unavailable.

Striano (1988) describes ways in which she believes psychotherapists can hurt their clients - by mistakenly diagnosing symptoms of a physical illness as 'psychological', by sexual or financial exploitation, by encouraging dependency, by entrapment in cult-like systems, by pathological labelling, by extreme passivity, by encouraging introspection at

the expense of practical action in the real world, and by compounding low self-esteem. No doubt the implantation of false memories would now be added to the list.

The likelihood of a conventional licensing system providing an effective means of protection or redress in these cases is pretty slim. As discussed in Chapter 9, we have little reason to be confident that statutory systems of regulation based on restrictive entry requirements, the disciplinary enforcement of professional codes of ethics and practice and the outlawing of unlicensed practice will effectively protect the public. If protection of the public from harm has not been a proven consequence of such systems *in general*, there is little prospect that such a system would protect the public in a field as indefinite as this one. To believe otherwise represents a triumph for wishful thinking.

However, pitfalls such as those cited by Striano can be addressed by other means that are less harmful to the public interest. For example, educational endeavours directed at both practitioners and the public, the application of general laws (such as those concerned with contract, deception, truth in advertising, assault and non-consensual sexual behaviour) and the other alternatives explored in Chapter 28.

The vast majority of what goes by the name of psychotherapy consists of little more than two people conversing in a room and not even a case of one of them giving professional advice to the other. As Combs points out so elegantly in the quotation that opens this chapter, the question of regulating such an activity by licensing is actually quite a sensitive issue in a free, democratic society - and not one to be undertaken lightly. Being 'licensed to talk' has civil liberties implications!

Chapter 14

Licensing and Psychotherapy - Qualifications, Standards and the Requirements of Entry to the Occupation

The fact is that consumers of mental health services choose therapists on the basis of their credentials and licenses granted by government, but neither credentials nor licenses bear any relation to patient improvement.

... The studies all indicate that long years of academic training are not a prerequisite for competence....

(Roberta Russell, 1981/1993)

... Accreditation procedures tend to be forced back onto the most easily measured parameters, which in this situation are the least significant. Books read, courses attended, training analysis, or numbers of hours spent under supervision, intellectual understanding of the issues involved - none of these are necessary, let alone sufficient criteria of competence in the therapeutic engagement. One thing that does emerge from outcome studies is that it is not so much the paradigm, the ideological framework, or the particular skill set involved that makes a difference, but the quality of the interpersonal relationship established between therapist and client. Seen in this light truly the therapist has no clothes and accreditation is an attempt to generate a veritable Emperor's wardrobe of nonsense.

(David Wasdell, 1992:5)

This chapter addresses precondition for licensing (*h*) - *the purpose of licensing must be the prevention of harm.*

Hogan argues that a licensing system *may* be justified if the conditions for licensing are fulfilled. However the purpose of such a system should be to establish *minimum* requirements for safe practice, not to maxi-

mize standards (however conceived) because of the aforementioned detrimental effects of licensing such as increased costs of services, reduction of supply of practitioners and the stifling of innovation.

As we have seen, UKCP is pursuing a path of accreditation and is concerned to promote a situation in which no one would be able to call themselves a psychotherapist without first having to meet the “high” standards it espouses. It claims that this will protect the public from the “unqualified” (UKCP, 1993a & f).

The agreed baseline criteria for acceptance of training organizations by the Council include the requirement that entry to training should be “at a postgraduate level of competence” and that the training be at a postgraduate level, have M.A. equivalent content and not normally be shorter than three years part time (UKCP, May 1993f; Pokorny, 1992). Exceptions are made for those without degrees in some cases and ways around this requirement offered (the UKCP literature, e.g. UKCP, 1993c, makes reference to Accreditation of Prior Experience and Learning (APEL) whereby previous experience and learning can be accepted as an alternative to satisfying normal entry requirements to courses) but the overall values espoused are those of promoting psychotherapy as a *postgraduate* occupation. APEL is the back door not the front. In 1991 UKCP (then UKSCP) reached agreement on: “forming a postgraduate level profession with specific entry and training criteria” (UKCP, 1993b). Whatever other purposes they may serve, these UKCP criteria are also clearly intended to be compatible with European Community legal requirements for the recognition of professional ‘diplomas’ at the university level (see Chapter 3).

The possession of academic credentials from an accredited institution is a traditional prerequisite in licensing systems but one which is difficult to defend in this area. UKCP is promoting an increased academic content and higher academic prerequisites for training when the evidence available is that this skewing towards intellectual skills is not particularly relevant to competence in this area. *There is little if any evidence that the possession of academic qualifications by psychotherapists relates to basic competence or protects the public in any way.*

... The existing empirical evidence suggests that licensing efforts to date have focused on the wrong variables. No evidence

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exists that possession of academic credentials protects the public. Surprisingly little if any evidence exists that the particular school of the therapist, the techniques used, the amount of knowledge, diagnostic ability, or extent of training makes any difference in achieving minimal therapeutic results. Instead, the findings indicate that personality factors may be the most influential in determining whether a therapist is competent to practice.... (Hogan, Vol. 1, 1979:370)

As indicated above, statutory licensing should be concerned with the prevention of harm, rather than fostering the highest quality of practice because of the negative side effects of licensing. This is relevant here where what can at best be regarded as enhancements are put forward as baseline criteria. (The over-intellectual focus of the typical academic degree, especially in the realm of psychology, may actually be counter-productive as a prerequisite for work in this area. All too often, degree courses in psychology are a disappointment to those in search of self-knowledge.)

In many countries where there are legal restrictions on the practice of psychotherapy, for example some of those in Europe and many states in the USA, an academic background in medicine or psychology is regarded in law as an appropriate training, or necessary prerequisite, for the practice of psychotherapy. Even where psychotherapy is registered as a distinct profession, medical practitioners will often be exempt from registration. There is no sound basis for this (see also Appendix E).

In most US states the academic criterion for licensing as a psychologist, and hence often for practice as a psychotherapist, has escalated from a master's degree to a doctorate - a research degree with even less relevance to basic competence.

Encouraging such irrelevant criteria for access to training and practice constitutes an effort to raise the barriers to entry for the occupation and has various deleterious effects as previously indicated, including discriminating against those social groups such as the poor, ethnic minorities etc. that are less likely to possess academic qualifications. Raising barriers to entry to a market is a common monopolistic strategy. In the case of the professions it is usually effected by gaining legal privilege, in other areas such as say, soap powder, it is effected by tactics such as multiple product

lines to swamp the market and huge advertising budgets which raise the cost for new entrants to the market.

Likewise, extending the required duration of training to cover things that are not essential to basic competence but are at best enhancements, obviously also restricts access to the occupation through the resulting increased cost of training and the increased commitment of time involved.

The claim that statutory registration will protect the public from the “unqualified” is also challenged by the finding that *there is no clear evidence that professionally trained psychotherapists are in general more effective than paraprofessionals* (Berman & Norton, 1985; Russell, 1981/1993).

This is not altogether surprising when one realises that the “wrong variables” have been focused upon. Privileging those with a background in medicine or psychology, lengthening the courses, increasing the academic prerequisites and content do *not* favour the most important variables that relate to basic competence in this area. Pre-existing personality factors are of: “overwhelming importance in promoting personal change” (Aveline, 1990:321).

This does not imply that training is unimportant. I would not advise anyone to go to a practitioner who has not been trained in the work that they are offering (but I would not want to prevent them from doing so either). Rather, the point here is to highlight the issue of what factors it is most relevant for training programmes to promote.

The personal qualities that are prerequisites for competence in this sort of activity cannot be ‘trained in’, they can only be encouraged out. There are skills to be learned and knowledge to be acquired (and as discussed in Chapter 18, the guidance of experienced practitioners is crucial here) but without the personal qualities of the practitioner being regarded as fundamental, the ‘heart and soul’ of the matter may be left out of the process.

Personal integrity, inner ethical standards that reflect that integrity, an ability to be empathetic and the capacity to be autonomous are the sort of qualities that need to be encouraged. What training environments best facilitate the emergence of these qualities in the budding practitioner? Does the direction in which training is encouraged to go by UKCP foster this? Can, for instance, required conformity to irrelevant academic criteria set

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by an authority with little claim to democratic validity foster independence of mind and spirit? I think not. The structure of training environments should *at least* not suppress or inhibit those personal qualities known to be of particular significance to the activity for which training is being undertaken and should not discourage those who manifest these qualities but lack academic qualifications or abilities.

The skewing towards academia promoted by UKCP obviously in part reflects the significant presence therein of conventional and established bodies with a particular interest in preserving the importance of academic qualifications as the 'front door' to this 'profession'. The British Psychological Society,¹ the Royal College of Psychiatrists and the Association of University Teachers of Psychiatry are already Special or Institutional members and are apparently to be joined by the University Psychotherapy Association allowing graduates of University courses in psychotherapy a direct route onto the register (UKCP, 1993i). University courses in psychotherapy are apparently "mushrooming" (UKCP, 1994). Universities eager to get in on the act are also forging links with independent training programmes who are thereby able to offer the 'carrot' of a university M.A. on completion as an inducement to potential trainees.

The cost of all this, for those people who are still able to afford the inflated cost of training, will of course be passed on to the clients and, maybe, third party payers.²

For human potential organizations to have become a party to all this accreditation myth-making and inveigled into traditional 'hoop jumping' when it has so little relevance to the task at hand is, to my mind, a particularly poignant state of affairs.

Chapter 15

Licensing and Psychotherapy - Hogan's Conclusions

Psychotherapy and laws prohibiting unlicensed practice

Psychotherapy does not meet the criteria for licensing through laws that restrict a person's right to practice....

Apart from the definitional quagmire, psychotherapy does not meet many of the other criteria to warrant restrictive licensing. Although the degree of public impact is sufficient for licensure to be warranted, the evidence ... indicates that the negative impact of licensing is more likely to outweigh the positive benefits that are likely to flow therefrom. In addition ... other methods of regulation are available that promise adequate protection, but with less adverse impact. [See Section III.]

One of the basic reasons that licensing laws restricting practice to the credentialed few have little to recommend them is that sufficient information is not available about the extent and type of danger involved in the therapeutic process, whether the dangers are attributable to the actions on the part of the therapist, and what specific activities lead to dangerous results. Since so much disagreement exists on these fundamental issues, the value of licensing is seriously jeopardized. Until consensus exists on how to identify those therapists who are *not* dangerous, licensing standards will continue to be arbitrary and capricious. *Their actual effect will be to mislead the public into thinking it has protection from the incompetent practitioner.* (Hogan, Vol. 1, 1979:368-70)

Psychotherapy and title-protection acts

Psychotherapy should not be regulated through licensing laws, even if it is only the use of certain titles and representations

that is restricted. Even where licensing laws do not restrict a person's right to practice, requiring certain standards to be met before a person has the right to use specific titles is not advisable. Although title-protection acts have fewer disadvantages than laws restricting practice, their positive utility probably does not outweigh their negative potential.

It is true that title-protection acts do not present problems in defining what constitutes psychotherapy, since it is only the use of certain titles that is in question. It is also true that their impact in terms of raising the cost of services and restricting the supply of practitioners is less, since nonlicensed persons are not prohibited from practicing. On the other hand, if no impact occurs, the value of the law disappears.

The critical question is whether states are performing a valuable service by identifying practitioners possessing certain credentials as being competent. The problem is that little consensus exists as to what credentials are a sound measure of therapeutic competence, and the skills that seem important, such as empathic ability, are difficult to operationalize. Thus it is premature and misleading for the state to give approval to any one set of standards at this time. Instead, its policy should be to recognize this state of affairs and to teach the public that not enough is yet known about the ingredients of therapeutic success to warrant the use of restrictive licensing.

There is another political reason against title-protection laws. Professional associations are generally the sponsors of licensing. When initially seeking licensure it is common to recommend title-protection acts, since they generate less political opposition. Once these laws have been enacted, however, these same associations frequently seek amendments to transform the law into one that prohibits unlicensed practice as well. These Amendments often only involve minor word changes, and it is difficult to organize opposition to such changes. If for no other reason, this danger warrants extreme circumspection in advocating the adoption of any title-protection acts. (Hogan, Vol. 1, 1979:370-1)

Chapter 16

The Bases of Competence - Significant Criteria for Practitioner Selection

The selection of a therapist must be based on qualities as diverse and comprehensive as those applied to the selection of partners in other relationships - spouse, workmates, friends. The variables involved may be as basic as values or conceptual level, or as superficial as shoe polish, but the patient must be able to pick a therapist who talks his language, with whom he shares a mutual regard.

(Roberta Russell, 1981/1993:56)

Roberta Russell in her *Report on Effective Psychotherapy* (1981/1993) has comprehensively surveyed research into what factors have been shown to be positively related to the efficacy of psychotherapy and what factors have not. Russell's original report published in 1981, was supplemented in 1993, at which point the accuracy of its conclusions was confirmed by an American Psychological Association panel of distinguished therapy outcome researchers. This panel, which included Strupp and Grawe, also felt that the conclusions of the report could be refined by some of the results of the latest research on therapeutic alliance (*ibid.*:85) - findings which are included in the summary that follows.

The research surveyed by Russell indicates that the effectiveness of psychotherapy *does not* appear to depend upon any of the following:

- (1) *The practitioner holding academic qualifications.*
- (2) *The length of training of the practitioner.*
- (3) *The school to which the therapist belongs.*
- (4) *The practitioner having had a training analysis.* That is, personal therapy undertaken as part of a training process has not been found to relate to increased competence of the practitioner. Moreover, personal therapy will not render competent someone who lacks a basic talent for the role.

The effectiveness of psychotherapy *does* however appear to correlate positively with the following:

(1) *The degree of experience of the practitioner.*

(2) *The personal qualities of the practitioner.* Those qualities which can be roughly summed up as ‘empathy’ are particularly important. These include acceptance, genuineness, warmth, trust, and understanding. [Note however the point made by Smail: “... Empathy is of course important, but arises between people, and is not a quality (or ‘skill’) possessed by individuals in some finite amount” (Smail, 1983:14).]

The practitioner’s ability to perceive what is happening accurately is also important to outcome: “... Some therapists are better at this than others and this ability has more to do with effective therapist selection than formal training. One’s sensibilities may be formed out of the clay of our inherited temperaments and shaped by the interstices of life. The training of would-be professionals who do not have inherent therapeutic talent may be a poor use of resources” (ibid.:92). So, it seems that perceptiveness, (intuition?), talent and wisdom and are also important factors.

Personal skills, seem to be more important than particular techniques. Jerome Frank believes that the therapist’s personal qualities are the most significant factors and that techniques merely provide the ritual by which the personal changes are mediated (ibid.:89). [I myself believe that, for the humanistic area at least, both personal skills and those skills that can be regarded as the ‘craft’ of practice are important.]

(3) *The personal qualities of the client.* Included here are motivation to change (rather than for example satisfy addictive propensities) and the ability to form a working partnership.

(4) *The quality of the interpersonal or helping alliance - the congruent matching of client and practitioner.* This is even more crucial than ‘empathy’: “... Alliance as judged by the client, is an even better predictor of outcome than empathy” (ibid.:94). Asked what makes for a good therapist Arnold Lazarus said: “Being good doesn’t mean very much, and I’ll tell you why. ‘Good for whom’ is the question ...” (ibid.:51).

Such a congruent and effective match between practitioner and client depends upon: (a) the strengths and weaknesses of the particular practitioner that make them more suited to some clients than others; (b) shared

values and an agreement on the aims of the endeavour; (c) idiosyncratic factors are also very important. Luborsky has studied this latter issue and found that seemingly trivial factors such as whether or not the practitioner's shoes were well polished can be crucial in forming the necessary bond (ibid:52).

Given the importance of this congruent and personal matching between practitioner and client, Luborsky suggests that encouraging clients to try several therapists, and to make a selection on the basis of their feelings, will lead to better outcomes.

On the basis of this survey of psychotherapy outcome research, such as it is, the bottom line seems to be this: given access to appropriate information as discussed in Section III, clients are the best judges of who are the competent practitioners for them, and on the basis of their *personal responses* to practitioners (and the approaches that they offer) rather than on the basis of misleading criteria such as those that UKCP promotes. 'Up-*ping the ante*' to the practice of an occupation by establishing entry requirements that are not highly correlated with effectiveness restricts the size of the pool of people from whom the prospective client can choose an appropriate practitioner for themselves. The chances of them then finding someone with the appropriate personal characteristics - the major criterion of choice - are correspondingly reduced. This is all the more so when one realises the importance of idiosyncratic factors.

As mentioned in Chapter 13, Rowan has expressed grave doubts about the validity of even the best controlled outcome studies and he has responded in a similar vein to the conclusions in Russell's original report (Rowan, 1983:150). The studies surveyed by Russell indicate that factors which UKCP is promoting, such as extending the duration of training, raising both the academic content and academic prerequisites for training courses, and fostering links with universities, will *not* produce more competent practitioners. If this evidence is discounted, that still leaves us in the position that there is apparently little or no sound empirical evidence to support the notion that such moves *will* produce better practitioners. There is however, as previously discussed, a great deal of evidence to support the proposition that the establishment a regulatory system on the basis of non-proven criteria is detrimental to the public interest.

Chapter 17

Practitioner Selection and the Perils of Transference

... A national register of accredited psychotherapists would hopefully solve all such problems [involved in choosing a therapist], reducing the anomia and anxiety and ensuring that any client who wished to engage a therapist could pick a name from a list in full confidence that the service rendered would be competent, uniform and effective. Tragically, any such confidence is misplaced. A register of accreditation would provide a token or symbolic anxyolite, while in fact hiding the realities of confusion, uncertainty and unpredictability that underlie the choice making procedure. In this sense the drive toward accreditation that stems from client anxiety is a defensive manoeuvre, colluding with the public desire for a simplified and irresponsible decision making process.

(David Wasdell, 1992:5)

Competence in handling transference by its very nature is the one thing that cannot, without serious distortion, be professionalized and legalized in an emotionally repressive society. The professionalization of it takes it away from the public domain into mystification and expert knowledge accessible only to a few and this exacerbates and reinforces the very processes which it is supposed to be dealing with....

(John Heron, 1990:19)

Practitioner selection for the ‘decisionally challenged’

Protagonists of statutory control of psychotherapy frequently present the image of the potential purchaser of psychotherapy as being in such a state that they are incapable of making a sensible choice of practitioner. They are presented as vulnerable, distressed, traumatized, disturbed, lacking in autonomy or ‘rationally impaired’. Holmes and Lindley for example hold

that: “The patient is usually not in the position of a free purchaser. She is in distress, and is prone to grasp uncritically at any offer of help. The market does not protect old ladies whose pipes burst in winter from exorbitant and incompetent plumbers, and *a fortiori*, the desperation of someone in need of therapy may frequently lead to bad therapy choices being made by patients” (Holmes & Lindley, 1989:118).

The Foster Report holds that: “... it will not have escaped attention that those who feel they need psychotherapy tend to be the very people who are most easily exploited: the weak, the insecure, the nervous, the lonely, the inadequate, and the depressed, whose desperation is often such that they are willing to do and pay anything for some improvement of their condition” (Foster, 1971:178).

There is a certain circularity about all this. If someone is seeking psychotherapy they are *ipso facto* insufficiently ‘together’ to be fully responsible for choosing their psychotherapist!

Granted that *some* seekers are in such a state of distress that their adult functioning falls below a minimum level needed to retain adult responsibility for their choices and for whom the social role of being ‘sick’ (Parsons, 1953) is appropriate - they are indeed ‘patients’ in relation to the potential psychotherapist. However it is disingenuous to presume that *all* or most seekers are so impaired in their decision-making that they are sitting ducks for exploiters and that therefore special legislative arrangements should be made. This is all the more so if, as is the current tendency, the term ‘psychotherapy’ is being stretched to cover self-actualizing approaches such as in the humanistic area as well as remedial treatments for psychological disorders or mental illnesses.

In addition, the potential customer for psychotherapy is presented as being faced with a dauntingly difficult task of selection in a disorganized and complex field, crowded with a plethora of different types of work to choose from. Hence the need for systems of accreditation to sort the wheat from the chaff and ease the burden on this less than adequately functioning individual:

[A psychotherapy profession] would also help to overcome a real difficulty which exists for the consumer faced with the variety of psychotherapies.... The person in search of help is faced

with an array of different treatments, and is often not in a position or state to evaluate the distinctions between them, and so make an informed choice of therapy.... (Holmes & Lindley, 1989:217)

However, as David Wasdell points out above, the notion that the registration of psychotherapy would really help the potential client to choose is illusory and misleading. There are no easily applied external qualifications that you can trust. As discussed in the previous chapter, having selected a type of work that suits your intentions and values, the basis for deciding on a practitioner must essentially be personal. Moreover, since the available evidence does not strongly favour any particular approach as being generally more effective than any other, the choice of what type of work to undertake is less critical than it might at first appear and can be approached on the basis of what sort of work attracts you or by experimenting and trying out several types. In addition, rather than assuming that the consumer cannot become sufficiently well informed to become 'aware' enough to 'beware', and must instead leave fundamental parts of the selection process to a statutory board, the potential consumer can be 'informationally enriched' as discussed in Chapter 28.

The perils of transference

'Transference' is a term derived from psychoanalysis that refers to the unconscious assignment to the practitioner (or other person) of feelings about important and usually powerful figures in one's past (such as parents). Although this term is usually used in relation to a therapeutic setting, the phenomenon to which it refers is not confined to that context but is widespread, though seldom acknowledged as such. Transference is also a phenomenon which varies in its manifestation depending upon the expectations associated with the setting. The more it is 'the done thing', the more it will be done.

Much of the discussion about statutory control of psychotherapy has been heavily influenced by the psychoanalytic model in which transference is actively encouraged, since the analysis of the transference is the primary '*modus operandi*' of that approach: "... 'Deep' transference is an extension and exaggeration of everyday transference which occurs mainly,

but not exclusively, in analytic therapies whose arrangements, for example the passivity and reticence of the analyst, are especially designed to evoke it” (Holmes & Lindley, 1989:117). Frequent, regular sessions also tend in this direction. As we have seen (Chapter 5) Sir John Foster was heavily influenced by the psychoanalytic lobby in his report and the Sieghart Report was the outcome of a working party dominated by analytic bodies. Holmes and Lindley (one of them a psychoanalytically trained consultant psychiatrist/psychotherapist, the other a philosopher) favour a statutory profession and likewise seem to view these matters through a lens coloured by that model. However, from perspectives other than that of psychoanalysis, such as ‘holotropic therapy’ for example, transference would not be regarded as something to be encouraged but rather as a complication of the therapeutic process, a form of resistance rather than as necessary to successful treatment (Grof, 1988a:225). In humanistic and transpersonal approaches such as gestalt, psychodrama or psychosynthesis the relationship between the client and practitioner would be regarded as important, for example as a ‘container’, but transference would not be regarded as the main instrument of the work as in analytic approaches. Though awareness of the phenomenon would be included, actual encouragement of a transference would not necessarily be involved or considered appropriate.

Early in his career, Freud himself regarded transference as a form of resistance that impeded progress. The fact that he later abandoned this viewpoint should not be automatically taken as a sign of its redundancy. After all, Freud also abandoned the ‘seduction hypothesis’ of hysteria (that emphasized the importance of memories of actual childhood sexual abuse) in favour of a ‘phantasy’ interpretation, and he felt that this marked the beginning of psychoanalysis as a therapy and a profession (Masson, 1984).

There is no conclusive evidence that psychoanalysis or analytic psychotherapies are more effective than other forms of therapy (not to mention *cost-effective*!).¹ Therefore, it hardly seems fair that they should be used as the touchstone for legislative decisions - the more so if the ‘psychotherapy profession’ is supposed to include a gamut of other approaches, such as the humanistic ones mentioned above, as intended by UKCP.

Encouraging transference involves encouraging regression and dependency. Holmes and Lindley refer to therapy creating a temporary de-

pendency *en route* to a state of increased ‘autonomy’, the promotion of autonomy being the essential goal or outcome of psychotherapy. In a section describing: “some common elements in various types of psychotherapy”, they say that: “ Psychoanalytic therapy attempts, through the concept of *transference*, to make the issue of dependency-in-the-service-of-autonomy a central vehicle for therapeutic change...” and that: “... it remains true that some of the ethical dilemmas of psychotherapy do arise out of the ***cultivation of dependency*** in the service of increased autonomy” (Holmes & Lindley, 1989:5-7). Despite Sir John Foster’s claim that: “... More than ever today, psychotherapists regard the ultimate dissolution of the transference at the end of treatment as the most difficult, and yet most crucial, part of their task.” (Foster, 1971:177), the concept of ‘counter-transference’ and the usual inhibition of post-therapeutic contact between therapist and client, carry an implication that the ‘resolution of the transference’ is actually a theoretical possibility rather than necessarily the norm.

Autonomy, here, is a variable state of being. With regard to the safe selection of a therapist, discouraging transference and concomitant regression and encouraging what adult functioning and autonomy the person *already* has is the more appropriate stance. This means not colluding with any urges in the prospective client to forsake what adult status and responsibility they do have and the responsibility for choices that only they can make - including the choice of a practitioner.

Institutionalizing the transference

The accreditation route fostered by UKCP promotes the myth that the public can be protected from the difficulties of choice in this area.

The promotion of this myth is indicative of a process that I will refer to as *institutionalizing the transference*. This represents a further effect of licensing in this area that if anything actually *increases* the potential risk of harm to the public over and above the negative side-effects of licensing that generally occur.

Many institutions, individuals and professions appeal to and exploit transference - for good or ill. As we have seen some types of psychotherapy and related fields address transference itself and work with it directly and indeed an awareness and understanding of transference can be regarded as a basic competence in this field - and should be a basic social

competence. As Heron explains in the quotation above, promoting the handling of transference as the rightful province of a special professional enclave mystifies it and removes it from the public domain - where an awareness of it as a pervasive phenomenon rightly belongs. Demonstrating this awareness collectively as practitioners (and individually) would mean refusing to collude with a 'fear of freedom' that makes people yearn for someone else to relieve them of the burden of decision and take charge of their lives.² It would also involve practitioners refusing to act out their own urges towards aggrandizement.

Instead, we have the very occupation which should know better pursuing the myth of accreditation in this area and seeking 'official recognition', statutory privilege and monopoly. By so doing transference would become institutionalized in the sense that the practitioner's status as 'expert' would become endorsed by the state and his or her authority commensurately enhanced. Transference, and regression, are encouraged by anything that encourages you to 'look up' - from the couch onwards!

Potential clients can become lulled into a false sense of security and suspension of judgement by such a system. It encourages them to defer to the authority of the practitioner and the institutions backed by the state that give him credibility - to 'leave their brain at the door' - in a way that fosters dependency and a letting down of appropriate self-protective guards.

As with transference, so with hypnosis, suggestion, and subliminal influence. These are not techniques or phenomena confined to the 'therapy' room. Nor are they phenomena so discrete that they can be readily defined for the purposes of law without infringing on civil liberties. Can hypnosis and meditation, for example, be legally differentiated? Our culture is awash with appeals deliberately aimed to bypass conscious awareness. Our media are full of subliminal cues and emotive inducements and our politics full of 'feel-good factors'. Perhaps politicians should be licensed.

Once again the golden rule is to let personal judgement or recommendation be your guide. Remain circumspect and do not allow status to cloud your personal assessment of the practitioner and what they do and say. As sociologist Dr. Eileen Barker of INFORM - Information Network Focus on Religious Movements - has said of the so-called 'mind-control' techniques used in some cults: "the point is, the techniques they use are not irresistible" (*Focus*, 1995a:36).

The latest ‘hazard’ of psychotherapy to cause concern is the notion of the ‘false memory syndrome’. Alongside the encouragement of transference, interpretation is a favoured psychoanalytic technique. In the past, Freudian dogma has led psychoanalysts to erroneously interpret the emerging memories of sexual abuse of some of their patients as ‘phantasy’. The ‘false memory syndrome’ can be seen as a consequence of the further misapplication of that technique, whether by psychoanalysts or others, but in this case the error is in the reverse direction. A medical model notion of the practitioner as diagnostician of the underlying cause of symptoms is also implicit here and it is the attribution of a status of ‘expert’ to the practitioner that is likely to raise the client’s suggestibility and make them more vulnerable to such errors.

Much is made by registration advocates of the need to protect ‘the vulnerable’, but vulnerability in this context is not an isolated condition of personal make-up. It is proportional to the power that the prospective client gives away to the practitioner. Official recognition based on unconfirmed criteria *begets* vulnerability.

Safety here lies in retaining an appropriate degree of circumspection - appropriate to the degree to which competence *can* be assured. Supporting the potential client’s existing autonomy, whatever degree of ‘adult’ they already have, by empowering them with information and relevant questions to help them make the judgements that *only they* can make, is more appropriate than enhancing the official status of the practitioner with the accompanying assumption that competence has been assured. Greater safety lies in an encouragement to evaluate rather than to take on trust.

As Schutz says: “In the present situation [USA. 1979], I rely on the state to tell me who is competent. I passively submit myself to a professional, and if I do not like what he does, I sue him for malpractice. My role is very inert and childlike. If I, as a consumer, know that I am responsible for selecting a counselor, I am likely to assume a more responsible stance. In many cases, the very act of being responsible will have a therapeutic effect” (Schutz, 1979:157).

For those people whose autonomy really is already well below a necessary minimum for adequate adult functioning, the ‘low status’ system discussed in Chapter 28 may provide a form of practitioner regulation that is appropriate to state funded settings.

Chapter 18

The Training Business and the Business of Training

Sadly, the correlation between training and effectiveness as a therapist is low...¹

(Mark Aveline [UKCP board member 1993], 1990:321)

Wouldn't it be handy if newcomers went through a long and expensive training which offered lots of teaching and supervision work? Within psychotherapy people have begun jockeying for position, putting their training courses and accreditation procedures in place, inventing hurdles for the next generation - hurdles they themselves will never have to jump!

(Nick Totton, 1992:26)

Notwithstanding the significance of personal factors in practitioner competence, training *is* important. This chapter addresses the detrimental impact of the current bureaucratic endeavours on training opportunities and some of the less than altruistic factors that may come into play in relation to training programmes and lead to inflated costs of training.²

Trainers are not necessarily amongst the 'best' or most experienced practitioners (though they may be amongst the most ambitious) and yet they have the overwhelming say in UKCP compared with non-training practitioners (never mind clients, etc.).

Becoming a trainer in this field has significant appeal over and above being simply a practitioner. It often seems to yield a higher status and the power afforded to trainers by UKCP is likely to exacerbate this. People will be likely to assume that a trainer has sufficient experience to train others, whether or not this is the case (and certainly UKCP does not require it). This is an assumption that is likely to be compounded if any 'official' status is granted to UKCP.

In addition, being a trainer gives the possibility of a more 'captive' group of people to work with - trainees - who will be tied in for the duration of the course - three or more years and getting longer - a situation fostered by UKCP. This does not necessarily correlate with increased competence as we have seen. Trainees are also often more willing to pay over the odds for groups, etc. on the grounds that it is an investment which will pay off in terms of future earning capacity, rather than a non-recoverable (financially speaking) expenditure on their 'self' development. It is perhaps not coincidental that psychotherapy registration has become such a 'hot' issue during a period of economic recession. Traditionally, professions become more self-protective at such times.

Furthermore, where training requirements include personal experience in the modality in which one is training, as is the case in say the Humanistic and Integrative Psychotherapy Section of UKCP, trainees will be committed to be 'in therapy' for reasons beyond those of personal need or motivation, thereby 'steading' the income for the therapists concerned and indeed providing a guaranteed flow of clients, especially if there are 'in-house' requirement regarding with whom the trainees may work.

Prospective trainees are commonly not required to have had significant experience of the work in which they are training *before* being accepted for training - as a positive experiential basis for their ambition. This would severely limit the catchment for the training course and reduce the economic basis of the enterprise. Instead (or as well as) there will often be a requirement for trainees to have their own personal therapy during training in the modality espoused by the particular organization and their choice of practitioner may well be restricted to someone 'in-house' or a graduate of the organization. This produces a virtuous economic circle for the organization concerned. Where such a restriction is not the case, if current trends continue, it is increasingly likely that choice may be restricted to UKCP registered practitioners.

I am doubtful about the quality of personal growth work that can be effected as a course requirement. If it is being done in order to 'qualify' it is no longer really 'personal'. The pace and rhythm of it is no longer determined by personal growth factors alone and instead is subject to career ambition and compliance with outer pressures. For example, as discussed above, under these circumstances the 'client' is not entirely free to choose

who to work with but must instead work with an ‘approved’ practitioner and the frequency and duration of the work will often be specified by the trainers. Moreover, personal growth work that is too closely entwined with a career assessment process is in my experience very likely to be compromised by the actual (never mind transference) power and authority relationships with one’s trainers. Revealing oneself is less likely when there is a potential career penalty for personal revelations which may be adversely judged. In practice, it is unlikely that personal therapy and career assessment can be effectively separated when the former is a concurrent requirement of the latter. Szasz takes a similar view (Szasz, 1965, 1974:116). These factors may go some way to explaining the finding that, as mentioned in Chapter 16, having undergone a training analysis does not appear to correlate with therapist effectiveness. In a similar vein, I think that the ambition to be a psychotherapist, or whatever, of a particular school is one deserving particular scrutiny *unless* it has emerged as a result of an extensive prior positive personal experience of the modality in question - personal work during the course of training is just not the same thing. In practice, course administrators are under economic pressure to forgo such scrutiny - unless they have so many applicants as to be able to pick and choose. Significant personal experience of the modality in question, *prior* to training, is to my mind far more relevant as a prerequisite for training than, say, postgraduate level entry requirements.

As discussed in Chapter 6, the mere *prospect* of statutory recognition of UKCP may make it harder to start up a new training organization, effectively ‘freezing’ training in the hands of existing member organizations and stifling innovation. Michael Wibberley, an exponent of encounter groups since the 1970s, thinks that: “it is extremely unlikely that the kind of creative group work we do today could ever have evolved if the kind of restrictive measures proposed now had been in force before, and they may well restrict future developments” (Wibberley, 1994b:22).

Bureaucratic structures like UKCP are not the appropriate structures for regulating practice or training in this area. Just as the working alliance between practitioner and client is crucial to the positive outcome of that activity (and is not best served by such a bureaucracy) so a training relationship with an experienced practitioner is crucial to the business of training. Much of what needs to be learned will be done so more appropriately

by a process akin to ‘osmosis’ or ‘resonance’ - being taught by example - rather than by didactic presentation. The apprenticeship model, a model which involves working alongside a more experienced ‘craftsperson’ who can watch over one, from whom one can learn and to whom one can refer for guidance, is in many ways more appropriate (particularly for humanistic work) than training programmes modelled after traditional professional disciplines where a conceptual framework of theory is taught, learned and then applied. However, the apprenticeship system is one whose existence is likely to be less viable the more support there is for the deformation of training which UKCP and its ilk will produce. Perhaps this process is already more advanced than many realise. Guy Gladstone has the impression that: “new therapists are once again entering experiential groups outside of their trainings, informally reviving the vanishing apprenticeship model, a model which rests on the premise that becoming a therapist is a personally transmitted craft for which no amount of academic course work can substitute” (Gladstone, 1995:15).

Aveline (1990:327) is typical of those who favour a theory-followed-by-practice model of training as in a traditional professional discipline. He argues that theory should be the starting point (though it should be critically examined later in training). He comments that studying theory means that therapists do not ‘re-invent the wheel’. To my mind that is exactly the sort of thing they should be encouraged to do - to approach each client first and foremost with ‘open eyes’ and an open mind rather than be entrained from early on to see them through conceptual and categorizing lenses that become harder to remove the earlier one habituates to wearing them. After all, the conceptual frameworks of psychotherapists are hardly ‘wheels’. Whatever their variations, wheels are at least perfectly formed in their roundness. If wheels were fashioned in the likeness of the conceptual frameworks of psychotherapists we would all be having a very bumpy ride! As with children, so with trainees and apprentices, preserving and encouraging an exploratory freshness of approach to each person - a ‘Zen-mind, beginner’s mind’ (rather than an approach that is ‘play-impaired’ and fearful of making mistakes), is paramount. With that securely in place, conceptual schema can be drawn on as and when they are helpful like maps in one’s pocket. Do it the other way round and they become spectacles wired to the head. (See also Appendices F and G.)

Chapter 19

Carving up the Field and Doing the NVQs

Relationships [with UKCP and BPS] from my point of view are good. There is endless goodwill on all sides....

(Judith Baron, General Manager of the British Association for Counselling, 1994:14)

The more I hear about NVQs, the more I learn about them, the more I think they have the power to affect counselling as a profession and counselling in Britain and Europe. The reason is that they have government backing and a lot of money has been put into them....

(ibid.)

There are now at least five large professional organizations with an interest in statutory registration in this area - the UK Council for Psychotherapy (UKCP), the British Association for Counselling (BAC), the British Psychological Society (BPS), the British Confederation of Psychotherapists (BCP) and the Royal College of Psychiatrists (RCP). The problem of defining psychotherapy in any precise way means that there is considerable potential for overlap between the interests of these organizations. Despite the fact that some of them are also involved with each other, the prospect of statutory registration, being a form of monopoly at least over a title, puts these organizations into potential competition with each other - unless some form of territorial accommodation (cartel) can be reached. This is a process driven more by the 'needs' of the organizations to carve out territory in relation to statutory privilege rather than by any clear differentiations arising out of what their practitioners actually do on the ground.

As we have seen (Chapter 7), the psychoanalytic psychotherapists of BCP are unwilling to be subject to the hegemony of UKCP and in the event of statutory initiatives would want to be separately acknowledged. BPS has argued that state funded therapists should all be psychologists or

social workers and that registration of psychotherapists is really a question of the control of the private sector. Since the establishment of UKCP, some BAC members who regard themselves as practising psychotherapy and think that counselling includes psychotherapy, are worried about having to be members of two organizations (and pay two sets of fees for the privilege) and argue a case for BAC to redesignate itself 'The British Association of Counselling and Psychotherapy' (Rawson, 1993; Townsend, 1993; Tantam & Rickard, 1992). As previously discussed, BAC regards psychotherapy and some forms of counselling at any rate as being barely distinguishable. The Royal College of Psychiatrists has shown an interest in a statutory register of psychotherapists provided it has a central role in its administration and is in consequence a Special Member of UKCP. The psychiatric profession also has representation therein in the form of the Association of University Teachers of Psychiatry (AUTP), an Institutional Member.

Depending on your point of view, 'psychotherapy' could be conceived of as a type of counselling, a form of applied or clinical psychology, a form of psychiatric treatment, a discipline in its own right or a *mélange* of different things defying overall definition. What really counts in this context are definitions for legal purposes, and for such things as access to employment and the recovery of health insurance payments. Hogan has shown how professional organizations in the USA lost interest in meaningful definitions once a legislative scramble was under way (see Chapter 12) and as previously discussed, once registers become statutory, they can become self-defining. For example in the Australian State of New South Wales, a 'psychologist' *is* someone who is on the psychologists register (see Appendix B). Thus the 'carve-up' or legislative scramble reflects issues of organizational 'sovereignty' and power and, as indicated in the next chapter, even in the absence of statutory control, eligibility for National Health Service (NHS) employment and third party payment of fees constitute a measure of *de facto* regulation to be fought over.

Furthermore, the National Council for Vocational Qualifications (NCVQ), set up in 1986 as: "part of Margaret Thatcher's attempt to recreate a nation of professional shopkeepers" (Sarson, 1994), has set up a 'Lead Body' to promote the establishment of National Vocational Qualifications (NVQs) in this area. NVQs are sort of occupational 'driving tests' based

on demonstrable competence. A recent investigation of NVQs was less than complimentary about the system. Occupational 'driving tests' they may be, but they are driving tests in which your instructor is also your examiner since for reasons of cost, there is little in the way of external verification (BBC Radio 4, 1994d). The 'Lead Body for Advice Guidance and Counselling' has conducted a mapping exercise of counselling which includes - at the request of the BAC - a mapping of 'therapeutic counselling', defined as that form of counselling which goes into depth according to psychodynamic or other principles and lasts for more than a few months. UKCP supporters have expressed concern about whether there will be any territory left for 'psychotherapy' (and UKCP) to cover (Rowan, 1993c). At a June 1994 conference in London sponsored by the European Association for Psychotherapy (EAP) along with UKCP and BAC, the speaker from UKCP seems to have emphasized the importance of establishing clear boundaries between psychotherapy and counselling whereas the speaker from BAC seems to have played down the differences (Collis, 1994b).

At the behest of the Department of Employment the 'Lead Body' has commissioned a report on the feasibility of developing national standards for psychotherapy and encompassing psychotherapy within the 'functional map' of Advice Guidance and Counselling (AGC) (Consultants at Work, 1993).

At its annual conference in January 1994, UKCP voted to join the Lead Body for Advice Guidance and Counselling as urged by Sue Slipman, the Chair of that body, and to thereby participate in writing standards for NVQs in psychotherapy. The motion was carried despite much unease within UKCP about the prospect of NVQs:

... The general feeling reported by the twelve groups was that we really had a gun at our heads. If we refused to join the Lead Body, therapeutic counselling (BAC accredited) would step in to fill the place of psychotherapy. NVQs would probably become an essential requirement for employment in the NHS and that this would have a detrimental effect on the intake to training centres in psychotherapy if they did not offer these for training therapists.... (*Self & Society*, 1994)

The Lead Body's 'draft functional map of the psychotherapy domain' was produced by applying 'functional analysis' to the area in order to test the feasibility of: "... trying to "get at" the heart of psychotherapeutic competence in terms of ***the distinctive characteristics which mark it out from other forms of human endeavour***" (Consultants at Work, 1993:7).

'Functional analysis' is a system borrowed from studies of engineering and factory management. It involves defining a 'Key Purpose' and then deriving from this 'units of competence' which can then be analysed into 'elements of competence' which are (supposedly) minimal, self-sufficient competencies with both a range and a set of performance criteria and which can (supposedly) be taught and assessed, independently of other elements.

Some of the psychotherapists who participated in the mapping process were disinclined to accept that a methodology which might be adequate for engineers could also describe what psychotherapists do. They felt that such a process would fail to mirror the intuitive aspects of psychotherapy and inevitably lead to a narrow, mechanistic, reductionistic approach (ibid.:4-5). How true.

Regarding these misgivings, the view taken by the consultants responsible for the analysis was that: "... As psychotherapists operate with at least one model of the mind which informs their actions and acts as a guarantor of their professionalism, then it must be possible to reference their actions against this model. In this way activity is rendered intelligible to others and hence amenable to assessment. ***If this is not the case then much of if not all the assessment and accreditation currently taking place within psychotherapy would be open to the same criticism as that being levelled at functional analysis***" (ibid.:4). How true!

The basis for this 'Lead Body' 'functional analysis' of the 'psychotherapy domain' is the following proposed 'Key Purpose' statement for psychotherapy:

[To] assist people to address their experiences by creating a structured therapeutic setting informed by an accepted ethical framework and drawing upon a developed body of psychological theory in order to produce psychological change.
(ibid.:annex:1)

Applying a bit of ‘analysis’ to this ‘Key Purpose’ statement for psychotherapy is instructive:

[To] assist people to address their experiences ...

Is that different from meditation? contemplation? the arts?

... by creating a structured therapeutic setting ...

It is tautological to use ‘therapeutic’ to define ‘psychotherapy’. Is a “structured setting” different from a church, a confessional, an ashram, a retreat, a club, a theatre, a school or a pub? What would an unstructured setting be like? Some practitioners might find working outside of a ‘structured setting’ more conducive for some clients.

... informed by an accepted ethical framework ...

How is this different from any other meeting other than say a ‘mugging’? ‘Accepted’ by whom? - the two or more people concerned? If so will not a contract suffice?

... and drawing upon a developed body of psychological theory ...

Some of the best practitioners may not be applying a ‘developed body of psychological theory’ (though there are so many to choose from and so many that contradict each other) but rather may be working intuitively. They may not be consciously applying a ‘developed body of psychological theory’ nor subconsciously applying one they may previously have been conscious of. Do good mothers mother on the basis of ‘a developed body of mothering theory’? Also, what is the boundary between a ‘developed body of psychological theory’ and a spiritual discipline?

... in order to produce psychological change.

Does ‘psychological’ include the body? the soma? the spirit? If so, where is the boundary with massage? with bodywork? with spiritual practices?

In addition as Rowan rightly points out in criticism of the ‘Key Purpose’ statement: “... It seems to me that the therapist does not *produce* change in the client. It is the client who produces or does not produce the change” (Rowan, 1993b).

The 'Key Purpose' statement does not distinguish the activity of psychotherapy clearly from others and is so broad a catch-all that human potential work for example could clearly be trawled in by it if such a broad definition became the basis for a practice act.

Subsequent levels of the Lead Body's 'functional analysis' of psychotherapy read like a design for the toy box of an 'obsessional neurotic' with 'schizoid' aspirations. It is an exercise in 'relationships by numbers'. (Perhaps friendships and the choice of an intimate partner might also benefit from this rigour?) It is not really relational at all and assumes that the locus of change lies primarily in the psychotherapist's skills.

The whole exercise of attempting to measure the 'elements of competence' reminds me of the application of 'cost-benefit analysis' in relation to social policy such as the siting of a new airport or road development. The *appearance* of accuracy that the analysis presents simply misleads. What are at root issues of competing values and special interests (i.e. political issues) become disguised by a spurious coating of rigorous analysis. Thus the choice of whether or not to go ahead with a road development may hinge on the numerical values attributed in the analysis to the journey times of pedestrians versus car users or the numerical values allotted in the analysis to the loss of a view or a woodland.

One may doubt, as I do, the feasibility of *measuring* performance in this area in the way proposed by the 'Lead Body' but at least it has the virtue of shifting the focus of attention onto competence as such - however acquired - and away from the promotion of irrelevant prerequisites for practice or title usage.

So far the occupations to which the NVQ system has been applied have not been amongst the most prestigious, whereas UKCP has until now been aiming resolutely 'upmarket'. Instead of real 'standards', what we are liable to end up with from either system are bureaucratic standards - whether it be practitioners brandishing their NVQ 'empathy scores', or flaunting their UKCP approved postgraduate, professional status. (See also Brown & Mowbray, 1994b.)¹

Chapter 20

Third Party Payments and 'de facto' Regulation

... I feel the licensing procedure here in the US is humiliating, irrelevant, non-seeing and certainly unrelated to competency and commitment. It is a procedure entirely controlled by the Insurance Agencies and seems motivated by greed....

(Miriam Dror, 1990:35)

Unfortunately, the mental health establishment continually attempts to tighten state licensing requirements. These laws supposedly are aimed at protecting the public from unqualified practitioners, but their main aim is to encourage health insurance companies to pay for costly services. Overall, licensure laws enable groups of professionals to monopolize the psychotherapy market by locking out unlicensed competitors while guaranteeing a steady flow of clients and high fees for themselves....

(Peter Breggin, 1991/1993:496)

... In the past, especially, health insurers were prone to pay for bills generated by psychiatrists but not by other mental health professionals. In order to qualify for reimbursements from health insurers, these other professions have tried increasingly to make themselves over in the image of psychiatry. In a field where innovation and variety should have top priority, limiting health insurance reimbursement to traditional look-alikes stultifies the field.

(ibid.:456)

In the realm of alternative and complimentary medicine, the debate in the UK about official recognition and statutory registration of such disciplines as osteopathy, chiropractic and acupuncture has focused not only on the protection of the public, but also on the eligibility of these methods for

recognition as treatments available under the National Health Service (NHS) or under private medical insurance schemes.

This 'eligibility of the treatment' issue is also a factor to be considered in the case of psychotherapy. For patients there is a question of having access to psychotherapy funded by the state or by private medical insurance as an alternative to the typical resort to symptom suppressing drug-based approaches with attendant risks of addiction and side-effects (see Appendix E). For practitioners there is a question of what status qualifies them for reimbursement of fees or employment in the NHS. That is, who would be recognized to offer psychotherapy?

Eligibility for medical cover, whether state or private, categorizes the activity in question as a remedial treatment. Holmes and Lindley argue a case for state-funded psychotherapy on the grounds that emotional autonomy is an essential part of human well-being and that therefore the state should be responsible for funding activities directed towards the restoration, maintenance or development of a reasonable level of emotional autonomy in the same way that state provision of education is accepted (Holmes & Lindley, 1989). This may be a desirable vision, but setting aside the question of to what extent the education system is really concerned with promoting individual development rather than conformity and preparation for economic activity (Illich, 1971), I think one would be extremely fortunate to get treatment paid for by others unless one is seen by them as 'sick'. Psychotherapy when provided under the NHS or private medical insurance is almost by definition a remedial, medical model activity - 'psychotherapeutic treatment' - rather than a personal development activity. In pursuing access to NHS employment UKCP is by implication moving (closer?) towards an implicit medical model definition of psychotherapy. If not, self-actualization is to be funded by the taxpayer and the Department of Health has changed its spots.

As indicated by Peter Breggin above and as Juliana Brown and I have outlined elsewhere [see Appendix A], eligibility for medical insurance payments has been a factor in the development of licensing systems in this field in the USA. This has favoured a medical model rather than a growth model and has encouraged both practitioners and clients to classify aspects of the latter's experience or behaviour as pathological, as psychological disorders, in order to render attending to them a claimable item.

The 'bible' for this is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) which is modelled on the *International Classification of Diseases* (ICD). According to *Psychology Today*, the latest edition, DSM-IV: "... continues the classification mania set in motion in 1952 with the debut of the original DSM" (*Psychology Today*, 1993:17). And, according to psychologist Mark Hubble who regards DSM-IV as a fashion catalogue for mental health workers: "It's been a road to hell paved with expert consensus" (ibid.). From this perspective, DSM-IV is a catalogue of deviations from cultural norms. A classic example is that homosexuality was classed as a disease until dropped from the DSM in 1973 on the basis of a vote by the American Psychiatric Association (Grof, 1985:329).

According to Mitchell Wilson, DSM-IV furthers the medicalized "narrowing of the psychiatric gaze" by teaching doctors et al. to focus only on "the superficial and publicly visible" (*Psychology Today*, 1993:17).

How to make sense of psychiatry's diagnostic swelling? It may not accurately reflect the nature of human problems, say Hubble and Wilson, but it follows the widening scope of medications and the need for strict classification codes by insurers. (ibid.)

Having a diagnosis of 'mental disorder' may be financially beneficial in that you may be able to claim the cost of psychotherapeutic (or other) treatment against medical insurance or have it 'free' under the NHS. In the latter case this makes such an activity available to people who might not otherwise be able to afford it. However there is also a downside that needs to be taken into account. Psychotherapy categorized as treatment becomes part of your medical record and if you've received psychotherapeutic treatment *ipso facto* you've had a psychological disorder. Given the stigma that attaches to 'mental disorders' (often regarded as weaknesses or defects of character) having this on your medical record may have effects on your employment prospects, visa worthiness, etc. Of course, going to a practitioner privately need not in most cases become part of your medical record - nor your 'social' record.

There may be less stigma attached to going to see a 'counsellor' rather than a 'psychotherapist' as the associations with medical treatment are looser. However, it is worth noting that the UK government investigation

into the case of Beverly Allit (a nurse who killed and injured children in hospital whilst suffering from 'Munchausen syndrome by proxy') recommended that access to the nursing profession should be denied to people with a history of heavy use of counselling services (amongst other things) (BBC Radio 4, 1994a).

For practitioners, reimbursement of session fees by health care schemes and access to employment in the NHS are amongst the main economic cherries to be picked from the regulation tree. As indicated in Chapter 19, the prospect of access to NHS employment and competition from BAC has tempted a reluctant UKCP to join the Lead Body for Advice Guidance and Counselling (*Self & Society*, 1994:42). Counsellors are already making a home for themselves in the NHS. Under the new GP contract of April 1990, GP's may employ counsellors in their practices and it is estimated that 49 per cent of all fund-holding practices already have one, and 70 per cent or more of their wages may be reimbursed by the local funding authorities (Harris, 1994:24). Members of the recognized 'core professions', psychiatry and clinical psychology, are already regarded as directly eligible for NHS employment. There are posts for over a hundred consultant psychotherapists (medically qualified) in the NHS, the first having been appointed in 1964 (Holmes & Lindley, 1989:84) and there are approximately 2,500 clinical psychologists in the UK: "most of whom consider their primary responsibility to include the provision of psychological therapies" (Kosviner, 1994:289).¹

When work such as psychotherapy is undertaken under the NHS or the fees are recoverable under private health insurance schemes, a question of whether or not practitioners would be subject to medical supervision also comes into play. This issue of professional autonomy *vis-à-vis* the medical establishment has been a particular cause for concern for practitioners of alternative medicine contemplating the incorporation of their services into the NHS but reluctant to be subject to 'allopathic' control. In the context of NHS employment, except in those cases where the practitioners are themselves also medically qualified or perhaps members of that other NHS 'core profession' - clinical psychology, psychotherapists or counsellors are by and large regarded as 'professionals supplementary to medicine' and this seems something unlikely to be easily changed. As discussed in Chapter 7, the types of non-biological approach currently

favoured in the NHS (psychoanalytic and behavioural/cognitive-behavioural) have historically been subject to the influence of, respectively, medically qualified psychoanalysts and the championing of behaviourism by clinical psychologists in the course of their bid to carve out the status of a profession separate from medicine. Other approaches are now apparently making inroads.

The choice of criteria for employment or reimbursement involves the same sorts of issue as discussed for licensing systems generally, in particular the issue of whether competence as such will be targeted. On the one hand, where public money is being spent there is a strong incentive to do so accountably, on the other hand, state bureaucracies have tended to favour input criteria - the traditional reverence for professional status rather than output regulation and the monitoring of performance. There are also issues of immediate versus long term costs and of symptom relief versus 'cure' to be considered. Roberta Russell has referred to the: "age of accountability" in which insurance reimbursers and state funders of psychotherapy are increasingly counting the cost of psychotherapy provision and demanding clinical evaluation (Russell, Summer 1993:6). NVQs in this area may be seen as indicative of this trend and the creation of competing NHS Trusts leads in the same direction. It has been argued that, in this climate of increasing accountability, the need for practitioners to monitor and evaluate the outcome of their clinical work will become more urgent if renewable licenses to practice are introduced (Wilson & Barkham, 1994:50).

In Section III, I will discuss an alternative model for the provision of psychotherapy-as-treatment in those health care settings where third party payments apply, a model which avoids many of the pitfalls of existing approaches.

In those countries where there is no specific statutory regulation of psychotherapy, restrictions on eligibility for employment and reimbursement can provide a measure of regulation of an indirect nature. In much of the European Community/Union, for example, eligibility for reimbursement of fees for psychotherapy under health insurance schemes is limited to psychiatrists or in some cases psychologists as well (European Parliament, 1993; Young, 1990).² Given sufficient acknowledgement by state and private health care funding systems, even without statutory registra-

tion, professional organizations may come to exercise a degree of power over access to employment and fee reimbursement that amounts to a form of indirect, *de facto* regulation - at least of psychotherapy or counselling offered as *treatment*.

What may be referred to as 'self-regulation' may in fact become a case of market control - *de facto* licensing not too far removed from that achievable through statutory means. Moreover, acting alone or in concert with others (as a cartel), professional organizations may dominate the market sufficiently to control access to such things as advertising in journals, using/renting premises and employment by agencies in the private or voluntary sectors as well as the public sector. A tie-in with insurance companies may occur whereby employers may require prospective employees to carry professional indemnity insurance (see the next chapter) and yet insurers only recognize members of the professional organizations as being eligible or the employing agency's insurance may require membership of, say, UKCP or BAC by employees as a prerequisite for cover. Domination of training and accreditation is of course a main avenue to such control of the market-place.

Even in those countries where statutory licensing does exist, such factors may in fact operate as a main form of control. For example in the North American context even where a practice act applies, 'in practice' the main mode of enforcement of unlicensed practitioners may be via the restriction of access to a 'billing number' (and thereby to third party payments for treatment i.e. state or private medical insurance payments) to licensed practitioners. The unlicensed are in effect 'starved out'.

It is really quite remarkable how professions in numerous fields and many countries have managed to accrue to themselves such monopoly powers, whether of a *de facto* or *de jure* nature, in a way that would be quite unacceptable in other parts of a market economy. 'Protection' has been sold to a trusting public and all too often skillfully massaged into protectionism.

Chapter 21

The Codes of Practice of ‘Defensive Psychotherapy’

... this form of market-failure analysis [which centres on the issue of quality assurance by seeking to relate the quality of outcome to the nature of services] is predicated on an assumption that *someone* (if not the consumer) can reliably determine “satisfactory” outcomes and “appropriate” services. In other words, if ignorance about what is a good or bad outcome, or what is a good or bad procedure, is not asymmetrical but pervasive [i.e. it is not only the consumers who are ignorant of these things], then psychotherapy begins to resemble astrology in that no settled bench marks can be identified upon which to base any regulatory strategy directed to promoting service quality....

(Michael J. Trebilcock and Jeffrey Shaul, 1982:276)

For the past few weeks, the attention of the legal and medical communities in the United States has been focused on an extraordinary civil case being played out in the Napa County courthouse in the heart of California’s wine country. There, Mr. Ramona is seeking to persuade a jury that he should be paid more than eight million dollars damages by his daughter’s therapist and a psychiatrist because, he says, they planted false memories in her mind. The trial is considered a landmark case. Legal experts believe it is the first example of a non-patient suing a therapist for damages over allegations resulting from “recovered” childhood memories....

(Phil Reeves, 1994)

It is a requirement of UKCP registration that practitioners take out professional indemnity insurance (UKCP, 1993g). BAC counsellors are “encouraged” to do so (BAC, 1993), as are BPS members (Dobson, 1995:3).

Professional indemnity insurance may be considered a badge of a

'proper' profession. It betokens the hazards that might arise through professional negligence and from which the public needs to be protected - over and above the legal obligation to exercise reasonable care and skill that behoves anyone offering a service. The case for the restrictive practice which is brought into being when a profession is legally backed is demonstrably weakened without the implication of such hazards awaiting the potential consumer.

Professional indemnity insurance insures the practitioner against claims of professional negligence or malpractice. Malpractice presumes a standard of good practice. In a field such as surgery, for example, where there is more of a consensus about the relationship between practice and outcome, malpractice may be quite easy to specify - leaving a pair of forceps in the patient, for example, is obviously bad practice. However the field in question is even less of an exact science than medicine or surgery, if it is a science at all. Despite the prevalent assumption of a medical model (which has given rise to the issues addressed in this chapter), there is in fact no consensus as to aims or means in this area. Rather than an evolved homogeneity there is a host of divergent opinions.

For example, what should be the role of touch? Is touching clients/patients a reprehensible practice as it might be regarded in psychoanalytic circles or is its absence a cause for concern as might be the case in the humanistic world? Are active techniques advisable? Does thrashing a cushion discharge rage or encourage violent behaviour? Does accepting a gift from your client represent an exploitation of them or not doing so a snub, a rejection of an urge to give, which would be counterproductive to the work in hand? Should 'dual relationships' be allowed? Is socializing with a current or former client acceptable?

The answer to such questions is usually "it depends". It depends so much on the context and the nature of the relationship between the two or more people concerned. It depends on their goals and their values, and cannot in many cases be reduced to clearly differentiated 'good' and 'bad' practices. There will be things that warrant a great deal of caution in a good many cases but may be appropriate in some. Furthermore the critical factors in this field seem to be personal factors rather than practice factors.

Guidelines, ethical and otherwise, and discussions of ethical dilemmas such as that by Tim Bond (1993) are valuable as cautionary pointers

to what may be potential problem areas - hazardous turning points on the road which the sincere practitioner will consequently negotiate with particular care. However, such guidelines will have little hope of having impact on the unscrupulous practitioner unless as part of the process of professionalization they become rigidified as *codes* of practice that have the status of rules and hence are capable of enforcement. Unfortunately this means of addressing the problem of the morally deficient practitioner has the effect of requiring a standardization of practice. In an area that should be concerned with the individuality of the client above all (from a personal growth point of view at any rate), this standardization of practice is akin to throwing the baby out with the bath-water. Moreover the presence of a code of practice is unlikely to really deter the seriously unprincipled practitioner, who may in fact be protected by the status that being a member of a recognized profession affords. Codes of ethics and practice are no substitute for inner integrity on the part of the practitioner. Clients should not be encouraged to believe otherwise and be lulled into a false sense of security thereby. Furthermore, if the history of other professions is anything to go by, the potential for self-serving behaviour and iniquity is more than likely to be constellated at the collective level by the process of professionalization.

In the absence of an evolved consensus, that is a reasonably homogeneous 'profession', malpractice (and hence malpractice insurance) cannot be grounded in clear unambiguous functional criteria. The basis for defining malpractice becomes the norms set by the professional organizations which have statutory recognition or dominance in the field, so that in effect good practice becomes what the profession says it is. Under this regime 'good practice' so easily veers towards what is 'good' for the profession - judged as what is safest for the reputation of the profession (remember that as discussed in Chapter 9, the 'Index of Visibility' bears the strongest correlation with disciplinary enforcement action).¹ These standardized criteria of practice then tend to become used by the courts to assess suits for negligence and by insurance companies as the basis for assessing professional indemnity claims - leading to further ossification.

What is fostered by such circumstances is not a fertile and innovative field but conformity of practice based not so much on true standards that are inherently related to the nature of the activity as on practitioner self-

protection - the practice of 'defensive psychotherapy'. Practitioners will do or not do things in order to avoid disciplinary action, malpractice suits and/or the invalidating of their insurance cover, rather than solely on the basis of whether or not the client would benefit.

In litigation-happy USA, where it is possible for plaintiffs to initiate an action without any financial risk to themselves, the increased prevalence of malpractice suits in the field of medicine has resulted in rocketing professional indemnity costs and widespread practice of 'defensive medicine'. The effect on the quality and availability of care has been: "disastrous" (Holmes & Lindley, 1989:184). For example, doctors are reluctant to practise as obstetricians at all in some states because of the risk of being held responsible for, and sued for, negative outcomes. Those who do practise tend to 'play safe', and if in the slightest doubt about the delivery, prefer to deliver by Caesarean section rather than risk the natural route since the Caesarean route gives them more control over the process. Consequently, for this and other reasons the USA has a much higher rate of Caesarean section than elsewhere.

Defensive medicine is expensive. Billions of dollars are spent each year in the USA on unnecessary investigative procedures which are primarily undertaken to protect the doctors from negligence suits - although they also add to physicians' incomes. For example, even a minor bump on the head will call forth a brain scan (BBC Radio 4, 1994e). The USA pays a higher percentage of GDP (Gross Domestic Product) on health care than any other country and paying for medical care is the leading cause of bankruptcy there. The practice of defensive medicine is a significant contributory factor to this level of expenditure (ibid.).

In the field of psychotherapy, malpractice insurance and malpractice suits have also become increasingly commonplace in the USA - and expensive/lucrative. Striano (1988) cites California's then costliest psychotherapy malpractice case as resulting in a six million dollar settlement to former clients. There is reason to believe that the proliferation of psychotherapy malpractice suits in the USA in part reflects the fact that the prevalence of professional indemnity insurance makes a suit worth pursuing (Hogan, Vol. 1, 1979:315,323). Moreover the level of damages that may be awarded is linked to the income of the defendant rather than just to the nature of the injury. Provided the practitioner has not invalidated the policy

by ‘non-standard’ practice, his or her own assets are not on the line, so the practitioner will refer it to the insurance company who may pay up to avoid litigation costs, whatever the justice of the claim:

... You may be upset with the insurance company’s willingness to settle out of court. Resist the impulse to clear your name.... Although settlement is not in the best interest of the professional [or justice], most malpractice cases are settled out of court at the pretrial stage due to the prohibitive cost of trial proceedings.... (Austin et al., 1990:20)

As discussed in Chapter 13, the question of harm in psychotherapy, especially with regard to causation, is problematic. Expedient bypassing of issues of causality and responsibility in the short term sows spores that will eventually manifest as decay in the system as a whole. With regard to the medical profession in the USA, such a system has been a costly and spurious exercise. Applied to psychotherapy where the risks of harm are low and the likelihood of establishing causation slim, it has done little to provide regulation and done much to smother innovation:

You should be aware that, if your practice deviates from what is considered standard treatment procedures by most other respected and qualified professionals in your particular discipline (i.e. experimental or nontraditional therapy) you risk being sued ... using experimental or nontraditional therapy leaves one vulnerable to both a malpractice charge and a charge of unethical conduct. “Generally, suits against innovative therapies have been based on negligence in techniques, assault and batteries (apprehension of and/or harmful or offensive touching without consent), or infliction of emotional duress” (Schutz, 1982:33).... (Austin et al., 1990:155)

When this sort of working environment prevails, practitioner self-protective caution gains the ascendancy. Whereas the practice of defensive medicine leads to a proliferation of unnecessary and expensive interventions so that the doctor can be shown to have taken all possible steps to counteract

a disease process, the practice of defensive psychotherapy tends towards passivity and a retreat into an interaction that is, at most, verbal - as foreshadowed by Freud's retreat from direct work with primary process and a cathartic approach. Unless there are standard 'treatment' procedures that you can fall back on, doing nothing very much is the best defensive option - just mirror what the client has said. Any physical contact with your client becomes circumspect. Don't touch or do bodywork - you may get sued for sexual malpractice or accused of having caused injury. Austin et al. specifically warn that initiating hugs with your client is risky behaviour (ibid:161). Don't suggest tasks or offer opinions on outer life issues - you may be held liable if they backfire. Don't suggest a causation - you may be sued for 'implanting' a false memory.

Apparently, not only have malpractice suits against practitioners proliferated in the USA but through the doctrine of 'vicarious liability' their supervisors have become implicated as well. According to Austin et al. (ibid.:230), a new trend in the USA is for supervisors to be named as defendants in malpractice suits brought against counsellors they are supervising. Some of the instances cited involve yet-to-be-licensed trainees, but it is not clear that this is so in all cases:

... Slovenko (1980) predicted that litigation involving supervisors is certain to be the "suit of the future." When one undertakes to supervise the work of another therapist, one also assumes the legal liability not only for one's own behaviour but for the acts of the supervisee.... (Austin et al. 1993:230)

So far, in the UK the likelihood of being sued, never mind successfully sued, for professional negligence as a psychotherapist has been almost zero. According to Kenneth Cohen, a solicitor who has studied the legal framework for the practice of counselling and psychotherapy in Britain, there has been only one case of negligent psychotherapy published in the English Law Reports and that concerned a psychiatrist. Furthermore it is his belief that: "... we are unlikely to see a dramatic increase in such cases because of the uncertain state of our knowledge about counselling and psychotherapy, and because of the general obstacles placed by the law in the path of any plaintiff in a negligence action ..." (Cohen, 1992:11).²

So, members of UKCP are required to insure themselves against a risk that is virtually non-existent at the present time. A similar situation applies in the world of Alexander teachers and Feldenkrais practitioners where professional indemnity insurance is compulsory for membership of professional organizations and yet there is a minimal recorded level of risk. According to Dobson (1995:3), more than 5000 psychologists and counsellors in the UK have been persuaded to take out insurance against negligence claims, including allegations of planting false memories of child abuse. Most of them have opted for cover of around £1 million. Perhaps it is time to buy some shares in the insurance companies concerned!

Unlike the US legal system, the British one has so far exhibited what is to my mind an eminently sensible reluctance to make hurt feelings in themselves a ground for compensation through the courts, unless they are such as to amount to mental illness or accompany a physical injury (Cohen, 1992:14; Bond, 1993:49). This is a position that reflects the difficulties of allotting responsibility in the area of hurt feelings.

I do not think it is wise to encourage a litigious adversarial approach to the sort of difficulties that may arise in relationships of this nature. Seeking redress of a financial or punitive nature via the legal and insurance systems is rarely appropriate for an activity whose stock in trade is 'unfinished business' of an emotional nature. Encouraging a settlement on the level at which the problem exists - the emotional, the relational, perhaps with the aid of a facilitator or mediator, is usually more relevant than fostering an escalation to the level of litigation and insurance claims.

In the USA the incentives to pathologize experience built into the US medical insurance system have combined with the stultifying effects of licensing, the promotion of 'defensive psychotherapy' through professional indemnity insurance and an escalating risk of litigation. The 'standards' promoted by such a system are not necessarily ones that correspond well to the nature of an activity where so much depends on personal qualities and environmental support for a very individualized response. This is a system that promotes standardized and conservative practice - practitioners and clients afraid to deviate from the average. It is a system that encourages a legitimized mediocrity rather than the variety of responses that the kaleidoscope of human nature requires. In my opinion such a system should not be allowed to take root here.

Section II

Human Potential Work and Psychotherapy

A Suitable Case for Differentiation

Chapter 22

Human Potential Work and the Rise of the Therapy Bureaucracies

We are concerned that if these moves [towards statutory registration] gain ground there will be a deterioration in the prevailing ambience of openness and choice. One of the fundamental principles of growth is choice, and introducing a system of regulation or licensing into the growth movement is liable to restrict choice. We feel that measures towards empowering the public to make more informed, responsible choices would be more in keeping with the spirit of the human potential movement....

Despite areas in common with existing institutions this field should not be subsumed under any of them. It is important that it retains its autonomy and continues to establish itself in its own right. It is important that the structures we develop reflect the underlying model and that we do not 'regress' and adopt structures appropriate to other models.

(Juliana Brown and Richard Mowbray, 1990)

Are human potential work (personal growth work), psychotherapy and counselling basically all the same thing? It has been argued that they are (e.g. Rowan, 1988:77). Certainly the activities that these terms have been used to refer to may employ techniques in common and from a superficial perspective they might appear to be the same sort of thing. However from a deeper perspective, the focus of human potential work differs markedly from, say, behaviour therapy, hypnotherapy, or psychoanalysis - as does the target clientele.

The issue of statutory regulation prompts a need for a clarity of definition and terminology that so far we have managed without in this area - witness the reams that has been written about psychotherapy, counselling and personal growth without specifying the differences.

At the political and legal level, the relevant definitions of psychotherapy et al. are intertwined with social role definitions such as adult/minor (child); healthy/sick; able/disabled; normal/abnormal and with questions of autonomy versus diminished autonomy and responsibility versus diminished responsibility. These are roles that are socially defined and self or socially allotted.

There are also the associated questions of which social categories the activity is bracketed with for purposes of law (whether existing law or new laws specifically targeted at the activity in question) and what categories it falls in for the purpose of funding and other matters. The question of whether the activity is regarded as a medical/mental health concern, an educational process, a religious endeavour, a cultural/artistic pursuit, a recreational activity, or simply a business activity has very practical consequences. For example, does the activity fit with town planning permission for the premises in which it is conducted? Is the activity regarded as a 'health profession' for the purposes of law or is it perhaps too spiritual or educational in orientation for that category? In the UK, categorization as a 'health profession' relates, for example, to the status of client/patient records. Under the UK's *Access to Health Records Act, 1990*, the records of 'health professionals' have the same status as medical records in terms of the patient's right of access to them. Medical records have social consequences in terms of employment and insurance assessment and may be called for as evidence in a court case or insurance claim. Clinical psychologists are defined as 'health professionals' under the Act, as are child psychotherapists, but practitioners of other types are not so far explicitly defined as 'health professionals' (Cohen, 1992:23-4). Lister-Ford and Pokorny take the view that psychotherapists generally will be regarded as 'health professionals' under the Act "once they have a register" (1994:155-6). 'Health professionals' may also be called to testify as 'expert' witnesses in court. Take the question of advertising. Under which section of the 'yellow pages' or other directories should the activity be classified?

In this light the *aims* of the activity and the *status* of the recipient are crucial to defining its nature rather than its methods or current labels. In the chapters that follow, I will be guided by this sort of perspective in spelling out the case for a clear differentiation between remedial 'psychotherapy' and human potential work (personal growth work) on the basis of

goals, values and intended clientele. In my opinion, the activities of human potential movement do not readily fit into the pre-existing social categories mentioned above and really deserve a category of their own.

Currently, because of the ambiguous use of such terms as 'psychotherapy' and 'counselling', some of what occurs under those labels would constitute human potential work and some would not. I propose a terminological clarification to prevent human potential work becoming inappropriately subsumed, to reduce a source of client confusion, and also to attempt to distance clients involved in human potential work from the stigmatization of the 'patient' that so frequently accompanies remedial mental health treatments.

The chapters in this section go on from the general case against psychotherapy registration outlined in Section I to address the question of how such professionalization would affect the human potential movement.

If the case against psychotherapy registration is strong, the case against human potential work (personal growth work) becoming involved in that process is all the more so. Some people seeking psychotherapeutic treatment do so as an alternative to suppressive approaches such as drug treatments and may be functioning with less than 'average' autonomy and therefore may be willing to define themselves as 'unwell'. However human potential work is directed at people who are 'as healthy as the next person'. They may be seeking change or personal transformation but would not fall outside of a category of 'average maturing adult'.

Without an appropriate differentiation between human potential work and approaches that focus on remedial treatment (and unambiguous terminology to match), policies and structures aimed at people who do not have sufficient autonomy to function adequately in our society may also become applied willy-nilly to those who do.

In addition, the introduction of a system of regulation into the field of psychotherapy when, as has been argued in Section I, such a system is neither warranted nor effective is liable to have a detrimental 'knock-on' effect upon human potential practice even if a clear differentiation from psychotherapy is maintained.

In my view, those who would like to retain a healthy human potential movement would be well advised to oppose the ambitions of UKCP and the other therapy bureaucracies - rather than participate in or acquiesce to them.

Chapter 23

Humanistic Psychology Joins in - the Humanistic and Integrative Psychotherapy Section of UKCP

Humanistic psychology looks up to people rather than looking down on them. One of the founders of the movement, Abraham Maslow says that he sees people as living organisms with an inherent need to grow or change. This is born inside them, part of their basic nature and it leads to a never-ending process of going into the self and going beyond the self. People involved in humanistic psychology study and try to experience ecstasy, creativity and transpersonal states as well as everyday functioning. These approaches emphasise a moving away from safety, and towards a set of values which Maslow calls the Being-values: the values found amongst people who have grown into something approaching their full potential as living human beings. In recent years a number of methods and techniques have been developed for fostering this kind of unfolding of human potential. *You* are invited to find out how humanistic psychology helps to generate a way of life, not only for you in your own private self, but also for you as a social being, a member of society.

(Introduction to "Self and Society" from 1975 to 1979)

It is well understood in sociology that nonconformist movements often mimic what they seek to change. The new professions of counselling and psychotherapy run this risk. Bureaucratic training bodies, accreditation bodies, brokers who sign up therapists and market them to companies, universities and hospitals teaming up with hitherto independent training centres all mimic the status system in British society.... The language of personal growth has been replaced with the lexicon of clinicians, clinical training, and psychiatric diagnostic systems. We risk going back to the oppressive, authoritarian culture of the head, emphasising theory and labelling at the expense of integration. We will lose the power of 'being with' in the

*Humanistic Psychology Joins in -
the Humanistic and Integrative Psychotherapy Section of UKCP*

transformation of suffering. Personal growth and empowerment risk going out of the window.

(David Jones, editorial, "Self and Society", 1994)

As with so many things, wide acceptance is even more dangerous than rejection....

(John O. Stevens & Barry Stevens, 1975:ix)

The journal *Self and Society* quoted above has been a mouthpiece for humanistic psychology in Britain since 1973 and has been closely associated with the Association for Humanistic Psychology in Britain, AHP(B), for most of that time. For its first 20 years in addition to various other subtitles such as "European Journal of Humanistic Psychology" it has carried the message: "A channel of communication for the Human Potential movement." This description was dropped in 1993 and *Self and Society* became simply "A Journal of Humanistic Psychology".

As will be discussed in greater depth in Chapter 25, humanistic psychology, pioneered by Maslow and Sutich, was a major contributor to the formation of the 'human potential' or 'growth' movement. As humanistic organizations in Britain have sought the bosom of UKCP, there has been a tendency to write off the human potential movement or reduce it to a humanistic psychology described as: "consolidating itself" and: "now part of the mainstream" (Rowan, 1992a:74).¹ Along with this, no doubt to avoid being: "condemned to practise psychotherapy as a 'therapist' " (Young, 1990:5), humanistic organizations and practitioners that would once have loosely referred to their activities as 'therapy' or 'growth', have increasingly gravitated towards the use of the term 'psychotherapy'. Thus for example the 'gestalt therapy' of Fritz Perls has for some now become formalized as 'gestalt psychotherapy' (see e.g. the brochure for The Gestalt Centre, 1994). Also, 'humanistic psychotherapy' has become increasingly adopted as a generic term and human potential modalities are in danger of being 'gathered' under such a term in a way that favours their regulation by the statutory body that UKCP hopes to become.^{2,3}

The Humanistic and Integrative Psychotherapy Section of UKCP (HIPS) comprises 19 organizations most of which both train and accredit.⁴ In terms of number of organizations in a Section this is the second largest

Section in UKCP, however as most of its constituent organizations are fairly small, its membership of approximately 500 practitioners amount to only about 20 percent of the practitioners on the register.

The “flag statement” of the Humanistic and Integrative Psychotherapy Section of UKCP holds that:

Humanistic psychotherapy is an approach which tries to do justice to the whole person including mind, body and spirit, and thus humanistic psychotherapists believe psychotherapy is not a medical practice and thus most often speak of clients and not patients.

Humanistic psychotherapists recognise the self-healing capacities of the client, and believe that the greatest expert on the client is the client. The humanistic psychotherapist works towards an authentic meeting of equals in the therapy relationship. (UKCP, 1993g:156)

However, although “patients” are not referred to in the *Criteria and Guidelines for Membership of the Humanistic and Integrative Section of the United Kingdom Council for Psychotherapy* (UKCP, 1993j), the document is littered with other examples of medicalized language and thinking. There are, for example, references to “psychotherapeutic treatment”, “psychopathology”, “clinical competence”, “clinical practice”, etc.⁵ Apart from the “Ethos” statement discussed below and a limp assertion that: “We also *favour* courses that take a holistic approach, paying attention to mind, body, and soul/spirit ...” (ibid.:1) inserted in amongst all the ‘shoulds’ and ‘musts’ there is to my mind very little in these criteria that is ‘humanistic’.

The document ends with a statement of “Ethos” which refers to the value system that the Section “holds as fundamentally important” (ibid.:9) and contains the principles by which they are to be guided in the shaping of a psychotherapy profession. However, try as I might, I could find little congruence between the criteria in the rest of the document and these fundamental principles from which they are supposed to have emerged.

Take their first stated principle: “that life itself brings as much if not more learning than any organized training. Therefore, *as much emphasis*

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needs to be placed on relevant life experience as on recognized qualifications or expertise” (ibid.).

How does this principle manifest in the criteria? It is not apparent to me. The criteria consider psychotherapy training as a: “postgraduate level activity” (ibid.:1) and include requirements of intensive study of theory as well as practice and some form of substantial written work or presentation. I see nothing there to indicate that a particularly rich personal background might lead someone to be accepted straight on to the register without passing through one of their approved training courses.

Take the principle that: “authority and responsibility shifts over time from the outer teacher or expert to the inner authority of an individual. In recognizing this, organizations and individuals need to protect the rights of self-determination within certain agreed guidelines” (ibid.:9). And similarly, that: “principles of empowerment of both individuals and organizations within which individuals are either working or training are highly valued and are embodied in the structures and systems of the organizations” (ibid.).

How do these principles manifest in the criteria? I’ve no idea. Practitioners are usually put on, and maintained on, the register by the organization that trained and accredited them. This is not a once and for all placement. Accreditation is seen as: “a renewable licence to practise” (ibid.:1). The organization reviews practitioners’ accreditation regularly and also their: “ongoing personal and professional development” (ibid.:4). So, unless there is an alternative route for them onto the register (which to some extent is provided by AHPP in this Section) practitioners are tied into, and subject to, their ‘parent’ organization. The UKCP complaints procedure also operates initially via the training organization.

In order to get onto the register, having completed the required number of years of training etc., the practitioner is subject to an evaluation which requires a minimum of four persons including at least one: “who has not been one of the candidate’s primary trainers, supervisors or therapists” (ibid.:2). That is three-quarters of your assessors could be your trainers, supervisors or therapists and not, for example, your peers. The choice of external moderator who, amongst other things, participates in and assesses the graduation process is: “*entirely* up to an individual organization”, though the Humanistic and Integrative Section: “*could* question a choice of mod-

erator” (ibid.:9).

Although one of the other principles in the “Ethos” statement is a strong valuation of unanimity or consensus in decision-making there is not even a mention of graduate participation in decision-making even though they are still dependent on the ‘parent’ organization for continued validation. Likewise, student/trainee participation in decision-making is not referred to, whether regarding accreditation or otherwise. What is more, unlike their ‘progeny’, the trainers themselves are rather free from prerequisites and scrutiny: “... ***We are not necessarily concerned with the credentials and intentions of the organization’s founders or present directors.*** We are more concerned with its actual existence and performance as a professional organization.” (ibid.:1) So the trainers are not for example required to participate in any form of self and peer assessment (see Appendix D). So much for the empowerment of trainees and a shift towards their inner authority! What hope is there of the clients - the supposed beneficiaries of all this - being inspired to empower themselves in the presence of the graduate output of such a system? If they do so it will be despite the system rather than because of the system.

As John Rowan has reminded me (Rowan, 1994), representatives of humanistic psychology were amongst the first to get involved in the development of UKCP, particularly those representatives who were associated with the Association of Humanistic and Psychology Practitioners (AHPP). AHPP was formed in 1980 as a sub-section of AHP(B) with a view to grasping: “the nettle of accreditation” (Rowan, 1991:32) and: “to act as a professional organization existing to promote the highest standards of excellence amongst practitioners of humanistic psychology” (AHP(B), 1992). AHPP was founded two years after the Sieghart Report (and two years before the first Rugby conference), with the therapy world awash with fears of UK government intervention. Later, fears of European Community/Union requirements were to take the ascendancy. AHPP is a member of the Humanistic and Integrative Psychotherapy Section as an accrediting body and does not do any training itself. It is one of the few accrediting bodies that accredits individuals rather than courses (Jelfs, 1992:17) and it has 73 of its practitioners on the UKCP register, a majority of its 100 full members (Collis, 1995:45).⁶

This practitioners’ ‘arm’ of AHP(B) seems in some respects to be

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more like a 'tail' wagging the dog. AHP(B) has a membership of about 870 (AHP(B), 1994) and is a registered charity whose constitution states that its objective is: "to advance the education of the public about humanistic psychology." (AHP(B), 1992) and yet the interests of the professional group - all of whose members are also required to be members of AHP(B) - have in some cases come to override this charitable objective. For example AHP(B) operated a referral service or resource directory of humanistic services for many years. By 1989 this had 240 people on the list. This original resource directory was unvetted and explicitly disclaimed any recommendation. This has been all but killed off because of opposition from AHPP who wished to convert it into: "a proper register of qualified practitioners" (AHP(B), 1989) and to foster AHPP recruitment by restricting the list to its members, thereby foreclosing on an alternative to membership of AHPP. An emasculated version of the AHP(B) resource directory remains but this is only distributed to members of AHP(B) on request and not to members of the public at large - AHP(B)'s constitutional target. Only the AHPP directory is distributed to the general public. In 1989 when the issue of AHPP taking over the list arose, Juliana Brown and I wrote to AHP(B) favouring its retention as an *information* service to the public but with the information therein to be verified on full disclosure lines (see Chapter 28). Unlike AHPP's activities, this proposal is in line with AHP(B)'s constitution as an educational charity and, we felt, also in tune with humanistic principles of encouraging informed choice.

AHPP is said to operate "semi-autonomously" of AHP(B) (AHPP, 1991b). Proposals were made in 1994 to change the structure of AHP(B) including trying to incorporate AHPP to the fullest extent, however this may cause difficulties with the Charity Commissioners (Burgess, 1994).

John Rowan has warned of the danger of humanistic psychotherapy becoming "absorbed into the medical system and treated as some kind of auxiliary medical aid" (Rowan, 1988:103), and the risk of the work being "twisted out of recognition" if legitimation is sought through NHS channels. He cites AHPP as an alternative route to recognition (*ibid.*).

With a view to preserving psychotherapy as an activity independent of medicine or psychology, AHPP supports the establishment of psychotherapy as an activity with the status of a profession (AHPP, 1991b), and is party to UKCP's drive for a statutory monopoly, a goal which is arguably

antithetical to the essence of humanistic work.⁷ The presence of AHPP and those other humanistic organizations which have joined UKCP⁸ has helped to modify the latter's institutions in a more humanistic direction than might otherwise have been the case. However, in pursuit of professional status, these humanistic organizations have gone along with all the non-humanistic features of UKCP, such as the academic bias, the aim of a postgraduate profession, the medicalized thinking and terminology, the lack of representation and the absence of any humanistic form of accreditation such as true self and peer assessment (see Appendix D). This has resulted in a situation where much humanistic training has become encumbered with excessive and inappropriate baggage⁹ and the whole endeavour fosters reduced choice and stultification. Yet these 'humanistic sacrifices' have been made when risks of absorption into the medical system or of statutory restrictions on the right to practise in the UK (other than as a consequence of UKCP, that is) have actually been rather slight. Instead, the medical model and the model of a profession akin to medicine have been allowed to creep into humanistic psychology. As John Heron, a founder member of AHPP, has said of the 1989 guidelines for full membership of AHPP:

... [They] represent a sorry mess ... [falling] between the stool of self-assessment and self-selection of practitioner categories, and the stool of imposed criteria for the category of psychotherapist imported from the UK Standing Conference for Psychotherapy. These criteria are not only imposed, they also appear to be restrictive and outmoded, implying a total separation within a closed, hierarchical professional enclave - of psychodynamics from sociopolitical dynamics. It is all very unhealthy, and looks as though humanistic practitioners are incongruently choosing a form of professionalization quite at odds with the interrelated values of self-realization and social transformation which have so far distinguished Humanistic Psychology. (Heron, 1990:23)

Perhaps it is time for a humanistic 'true self' to emerge from behind all this status seeking? An HPA (Human Potential Association) or an HPPCA (Human Potential Practitioners and Clients Association), perhaps?¹⁰

Chapter 24

Human Potential Work and Psychotherapy - Ambiguous Terminology and the Right to Practise

Why should all this bother me? I don't do 'psychotherapy' anyway. I don't like the term and its medical model associations and I don't use it. I'm a human potential practitioner, I call myself a 'personal growth facilitator'.

(Group-leader-with-his-head-in-the-sand, 1994)

I have used the words "therapy," "psychotherapy" and "patient". Actually, I hate all these words and I hate the medical model that they imply....

(Abraham Maslow, 1971:53)

An essential ingredient at the start of the human potential movement was the promotion of a growth model that focused on the development of *potential*, on self-actualization, on becoming more fully human, rather than the medical model's remedial focus on 'disorders', repair and cure. That is a focus more on "growth motivation" than "deficiency motivation" as Maslow would say (Maslow, 1968).

In our article "Whither the Human Potential Movement?" Juliana Brown and I argued that: "The current moves towards regulation and licensing derive from an implicit association with the medical model and with the medical professions as a model for professionalization." And that: "... in common with John Heron [and others] *we feel that terminology associated with the medical model (in particular the terms 'psychotherapy' and 'therapy') should be avoided by human potential practitioners*, at least officially ..." (Brown & Mowbray, 1990:33).

The term 'psychotherapy' is derived by combining two words with roots in classical Latin and Greek. The prefix 'psycho' derives from 'psy-

che' meaning: "breath, soul, life" (*Shorter Oxford English Dictionary*, 1973). The word 'therapy' derives from the verb 'therapeuo' meaning 'wait on, cure' ('therapeia' = 'healing'). Similarly, 'therapist' comes from 'therapeutikos' meaning 'a servant or attendant' (Taft, 1933; *Concise Oxford Dictionary*, 1990; *Shorter Oxford English Dictionary*, 1973). These ancient Greek meanings offer a possible interpretation of psychotherapy as involving healing through attending to the soul of another, and may therefore appeal to those of a holistic bent, but it must be remembered that these meanings derive from a time when there was no clear-cut distinction between medicine and religion and the 'therapeutes' were attendants of a god.¹ We, however, live in a time when medicine and religion are for the most part sharply divided and these ancient terms have already been borrowed by secular scientific medicine and psychology and applied in ways far removed from their classical meanings. Do you think of academic psychology as the study of 'breath, soul, life'?²

The combination of these root words into the term 'psychotherapy' was not undertaken by the ancient Greeks but is of quite recent origin. The initial use was by Johann Reil in 1803 in an article entitled "Rhapsodies in the Application of Psychic Methods in the Treatment of Mental Disturbances" (Hogan, Vol. 1, 1979:12). This first use was in the light of a medical model and the term is very similar to many other medical model terms. It is not so much that the term 'psychotherapy' has become medicalized and corrupted as Peter Breggin (1991/1993:463) has argued, but rather that, as with many other medical model words, the term was devised during the early years of scientific medicine using classical vocabularies as building blocks. Thus, like 'psychiatry' which combines 'psyche' with 'iatreia' (Greek for healing), 'psychotherapy' is a nineteenth century medical model word and the *Concise Oxford Dictionary* (1990) still defines it as: "the treatment of mental disorder by psychological means". The same source defines 'therapy' as: "the treatment of physical or mental disorders, other than by surgery" and as a suffix or second term, '-therapy' is standard usage in the world of medicine and psychiatry for 'remedial treatment' by the means referred to by the prefix or first term. For example, physiotherapy, radiotherapy, pharmacotherapy - or electroconvulsive therapy (ECT).³

The human potential movement has failed to give birth to a generally accepted term that succinctly makes clear the nature of its focus and, for

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want of a catchy alternative label, has slid into the widespread use of the terms ‘therapy’ and ‘psychotherapy’ despite their simultaneous medical model use to describe a remedial activity. After all, ‘therapy’ slips so easily off the tongue and it’s then but a short step to ‘psychotherapy’. Can anybody think of a really catchy alternative? ⁴

In a world where legality may depend upon the words that you use to describe your work (title protection), the choice of labels with which you ally yourself and with which you build up an association in the public ‘mind’ becomes a matter of *crucial* importance. After all, the drive for statutory registration in the UK is (initially at least) all about the control of the use of a label. Human potential practitioners have not fostered sufficient public awareness of an unambiguous distinguishing label for their work and have instead laid themselves open to a risk of losing autonomy by resorting to the use of pre-existing, ambiguous labels which for many people are strongly associated with medical models of curative treatment.

Practitioners may be clear about the differences between these models sharing the same terminology but I doubt that the ‘man in the street’ (never mind the government) is so well informed. In the 1994 Times/Dillons debate: “The Curse of Therapy” attended by about two thousand people, Fay Weldon, the protagonist, declared (unchallenged) that “therapy is cure” (and only a handful of those present voted against the proposition that therapists should be registered). Furthermore, many people have trouble distinguishing between a psychiatrist, a psychotherapist and a psychologist. Consequently, going to see anyone with ‘psych-’ on the front of their label carries a measure of stigma. They are all ‘shrinks’ to some (see Appendix E). This public ignorance compounds the use of ambiguous ‘psychotherapy’ or ‘therapy’ terminology for human potential work, and provides a ready avenue for the existing medical/health and/or psychology establishments to gradually move into a position of dominance or control of human potential work, a position unwarranted by any allegiance to the model of growth espoused or their actual involvement in the movement.

Despite the insidious ambiguity of the terminology in this area, I did not initially regard the existence of UKCP as other than an indirect threat to human potential work. Not regarding my own work as a form of psychotherapy anyway and having no desire to use that term, I adopted a line

of argument akin to that of the group-leader-with-his-head-in-the-sand quoted above. I did not believe that this sort of work could be regulated by some crude statutory approach and thought that nobody would be absurd enough to try. How could two people talking, or a group assembling, be legally regulated in a 'free' society? I now recognize that this was politically naïve and that a more active opposition is required involving a removal of as many heads as possible from the sand before eager register builders add the cement.⁵

As Hogan has pointed out, title protection is often all that is sought initially by professional associations because less political opposition is generated thereby. Once such a law is enacted it is relatively easy to extend it to include practice as well as title. Thus, if say the UKCP register is legitimated by government and allowed to become statutory, there is a significant risk of a shift from title protection to the restriction of activity also.

Eventually what may ensue is the restriction of the practice of whatever actual activity is deemed by UKCP to be 'psychotherapy' - and note that they have not so far defined what the limits of this activity are. Lack of definition has not been a bar to this sort of thing happening elsewhere.

Even without this risk of an escalation to a practice act, title protection of the term 'psychotherapist' would not necessarily be a benign event in relation to the right of human potential practitioners to pursue their craft. The restriction on use of that label is not all that is involved. (Note that, as mentioned in Chapter 6, UKCP also has ambitions regarding the labels by which various types of psychotherapy are to be known). Once a board is established, alternative labels can be 'mopped up' as and when they become popular. Remember also that the regulation of the medical profession in this country is essentially on the basis of title protection. In the Australian state of New South Wales, the Act that gives title protection to the term 'psychologist' also restricts the use of any title that: "is capable of being understood to indicate that the person practises psychology" - without defining what psychology is! Few alternative practitioners there seem to realise that their right to publicize themselves in any meaningful way is already in the hands of the psychology board! The alternative therapists of the state of Victoria only woke up to a similar legal reality twenty years after the Act had been passed. (See Appendix B.)⁶

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For all these reasons, not least the risk that UKCP may attempt to go beyond the title protection of the term 'psychotherapy', I feel that its attempt to legally restrict the use of this term should, from a human potential movement point of view, be resisted *even if one does not wish to use it*.

By the same token, the British Psychological Society's ambition to secure title protection for the term 'psychologist' would presumably mean that the title 'humanistic psychologist' would also be ruled out of use unless you were on the register of that society. (For example, in the Canadian province of British Columbia the term 'humanistic psychology' hardly features at all in the local growth movement since the term 'psychology' is legally restricted to those on the psychology register. See Appendix C.) Such a move could also be the prelude to a practice act governing the practice of psychology, including humanistic psychology, that could restrict human potential work to those on its register, *unless* such work were explicitly specified as religious and thereby benefit from the cultural support for religious freedom - such as enjoyed by the Scientologists!

Similarly, moves to have a statutory register of 'counsellors' would impinge on human potential practice. In North America the term 'counselor/counsellor' is often used in the growth movement (rather than 'psychotherapy' which has even stronger medical associations over there than here, and is in any case frequently unavailable unless you are a licensed psychologist or medical practitioner).

If each of the therapy bureaucracies is granted statutory privileges, scenarios that could transpire include a situation where title acts for 'psychotherapist', 'psychologist' and 'counsellor' coexist without any definition of practice. This might not be a such a problem for human potential practitioners who are content not to have access to these terms (other than by signing up) were it not for the risk of extension to cover practice and other labels as well, as discussed above. In that case, what might ensue would be a situation where there is a psychotherapy act, a psychology act and a counselling act each with title protection and a broad definition of practice (that could be overlapping or more or less the same in each case). Each act would be likely to have exemptions for people registered under the other acts (and as usual, medical practitioners) so that no one other than a registered psychotherapist, psychologist, counsellor or medical practitioner could practise, albeit under their different titles.

Section III

No Treatment Required

Section IV

Appendices

‘Case’ Notes

and

Bibliography

Appendix G

Supervision - Who's in Charge?

Supervisor - overseer, foreman, manager, controller, superintendent, superior, director, chief, head, administrator; invigilator; *colloq.* boss, super, *Brit. colloq.* gaffer, *sl.* governor....

(*"The Readers Digest Oxford Complete Wordfinder"*, 1993)

Unfortunately, it has become the habit amongst psychotherapists to call this process of seeking to enlarge one's range and depth of understanding by the rather inappropriate term 'supervision'. This term is easily misunderstood as belonging to student days, and is often queried by tax inspectors. In other professions it is recognised that any practitioner needs to seek the opinion of another practitioner about some cases - not necessarily difficult ones, nor must the help be sought from a more senior practitioner. Two heads are better than one. Seeking an opinion is normal in all walks of life....

(*Fanning, Pokorny & Hargaden, 1994:358*)

The term 'supervision', from the medieval Latin: 'supervidere', meaning to: "over-see" or "see from above", is yet another word with general and common-sense understanding that has been taken up by psychotherapists and counsellors and redefined in a way that may have a modicum of 'etymological correctness' but which conflicts with everyday meanings (and other associated terms e.g. 'superior'). In everyday understanding its use indicates a hierarchical relationship in which the 'supervisor' has authority and responsibility for overseeing the work of the supervisee. As used in the 'therapy' world, 'supervision' is usually supposed to indicate a non-hierarchical relationship with a "benevolent and experienced other" (Ziehl, 1994c) which provides an external perspective, feedback and support for the practitioner's work with the client, can be "an enormously helpful gift" (*ibid.*) and in which the supervisor is not usually seen as being responsible for the practitioner's work with the client.

BAC has recognized the drawbacks arising from ambiguous use of the term 'supervision', particularly in terms of confusion between super-

vision and accountability to management and has attempted to promote 'consultative support' as an alternative term. However, according to Tim Bond its use is falling out of fashion because: "... although it avoids confusion arising from the use of 'supervision', it too generates potential confusion over the term 'consultant', which to many people is associated with expertise and status rather than independence ..." (Bond, 1993:154).

Kadushin (1976) proposed a distinction between 'supervision', where the supervisor carries some responsibility for the work of the supervisee and 'consultancy' where the responsibility for the work remains with the consultee (Hawkins, 1985:74). Retaining the term 'supervision', Peter Hawkins offers a distinction between 'consultancy supervision' and 'training supervision' (ibid.:75; Hawkins & Shohet, 1989).

UKCP has also recognized the problematic nature of the term 'supervision' and at one time suggested "continuing professional development" (Pokorny, 1990:5). However, the term 'supervision' is what is currently used in UKCP documents. A 'supervisor's report' is required prior to the accreditation of a psychotherapist by organizations such as AHPP in the Humanistic and Integrative Psychotherapy Section (AHPP, 1994b). In this case the supervisor clearly has an overseeing function.

The everyday understanding that 'supervision' involves a hierarchical relationship seems likely to hold sway in the US courts (see Chapter 21), and I doubt that the 'therapeutic' revision of meaning will make much headway against the inertia of public common-sense understanding of the term, especially when the 'therapists' themselves use it ambiguously.

Compulsory supervision of therapists is held out to the public as part of the 'protection of the public through registration' argument. As a consequence of the confusion discussed above, unless they are particularly 'savvy', members of the public may be misled into assuming that an overseeing role is involved, whereas in practice the supervisor will rarely have had a direct experience of the practitioner's work and usually it is the practitioner who 'supervises' what is presented to the supervisor.

The basic notion of available sources of feedback, confrontation and support is one thing. However, if a requirement for supervision goes beyond that to specifying the *form* it should take, one should not discount the possibility that motivation for such a requirement may stem from the drive for professionalization and the business aspects of supervision and training since significant income potential is involved (see also Chapter 18).



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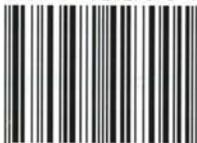
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