A View from the NHS

Lucy Taylor

As someone working in the NHS mental health service, I find John Rowan's article both interesting and thought-provoking. I want to put forward the viewpoint of some of those working in the NHS who have different practical considerations from those working purely in psychotherapy.

If we look at the relevance of his paper to the management of clients referred to the adult mental health psychology department, several points are worth mentioning. John Rowan touches on many valid points from a psychoanalytic viewpoint, but this is not necessarily appropriate for those working in the NHS who may practice a range of therapies, including cognitive behavioural therapy, the main differences being the limitations on time and the specifics of the help which the client requires. He talks of 'psychotherapy' in very general terms but does not specify what particular school of thought the therapist belongs to. One might argue that it should not make any difference, but I feel that, for example, from a cognitive behavioural stand it is important to establish 'goals' at the beginning that both the therapist and client agree.

There is no doubt that 'when the client goes back into everyday life, the application of whatever was learned or transformed in that moment is the responsibility of the client'. However, I feel that one cannot generalise in saying that any improvement of the client is purely self-achieved, as I feel that the therapist must have more responsibility than Mr Rowan implies, even if only to act as a catalyst.

In the NHS outpatient service, clients often require immediate practical help as to how to function on a day-to-day basis and, unless the agreed goals are met, the client cannot be satisfied. It is often the case that clients require a structure where the aims are clear and it is apparent that the therapist is also doing their utmost to encourage achievement. This seems particularly relevant when carrying out behavioural work, such as dealing with phobias.

It is important to mention the work with sex offenders. In this case the goal, which may well be an attempt to keep the client out of prison, is often shared and responsibility for progress lies both with the client and the therapist. On the other hand, when working with the victims of sexual abuse, an important part of the therapy is to give the control 'back' to the client and not to force the pace of therapy. Transference is an issue as the therapist can become the 'abuser' but at the same time the client might have the fantasy of the therapist as the 'rescuer'. This may create anger if the therapist is not able to fulfil the role at all times, which inevitably

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happens working within the NHS.

In this way I would stress the danger of generalising about 'therapy' — which covers wide-ranging conditions which may well require different types of relationship between the client and the therapist. The author asks at the end of the article whether everyone agrees with what he has written. Who is everyone? Certainly in the NHS the objective both for the client and the therapist is often a short sharp intervention which requires that the aims must be recognised right at the commencement of therapy.

The Fantasy of 'Cure'

Douglas Mathers

In this response to John Rowan's article I focus on two key words — cure and countertransference. First, I wonder what he himself means by 'cure': relieving symptoms, producing an enlightened being, or even 'getting the client to move from adjustment to ecstasy' — perhaps apt in sexual therapy? What does 'cure' mean for bereaved people, sexually abused people, those with borderline personality disorders or severe narcissistic wounds? Maybe as a Jungian and naturally pessimistic, cure seems a wonderfully optimistic word to use in assessing the outcome of the dialectic between patient and analyst. The *Journal of Psychotherapy Research* regularly has articles on outcome — the usual word used to describe a post endpoint assessment. But Rowan's article mentions nothing about outcome research, nothing about process research, nothing about research. This isn't an article about whether therapists cure patients — it is a political polemic. NVQ is the clue.

The Government is justifiably concerned about good practice in therapy, particularly as this word is now used by those who claim to cure psychic pain with anything from pretty smells [aromatherapy] to enemas [colonic therapy]. The latter has the advantage that the outcome, shit in the pan, is easily seen and measured. To clarify the present mess in our profession we do need to speak to the Government, as we would to any patient, in language they can understand. Words like 'outcome' and 'cost benefit', maybe even 'quality of life' — probably not words like 'cure'. As John Rowan hints, this word has overtones of messianic hopefulness and naïvete.

The second word is countertransference. What does 'deeply into countertransference' mean? This is a technical word with specific meanings. An excellent, though long, definition is given in the *Critical Dictionary of Jungian Analysis*. Jung regarded it as a vital source of information for the therapist. For Jungians, 'deeply in the

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