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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countertransference' is where the work is done. Whether a complex technical term needs to be used in a polemic I am not sure, but if it is, it may as well be used correctly.

It is the nature, perhaps even the function, of governments to be omnipotent. Rowan's quote from June Singer describes an experience common to therapists recognising and coming to terms with their own omnipotent fantasies. 'Cure' is such a fantasy. So is to imagine working 'without desire'. I know I need money, love and admiration as well as the occasional illusion that my work benefits my patients. Maybe what matters is recognising what constitute acceptable professional boundaries here?

So, when we negotiate with the Government to establish these professional boundaries this requires utmost clarity. Polemics need to be clear, but not simplistic. As H.L. Mencken, the famous American journalist once said, 'For every difficult and complex problem, there is a solution which is simple, uncomplicated — and wrong.'

The Gospel According to St. John

Windy Dryden

As usual, John Rowan makes some important points in his article. However, he makes some other points with which I take issue. Let me comment on his points and add some others of my own.

Therapists do not and cannot cure clients

The concept of 'cure' is a problematic one in psychotherapy. It conjures up the image that the client has an illness and the psychotherapist will administer treatment, the purpose of which is to eliminate the illness. This is, in my view, an unsuitable metaphor and I would expect him to agree with me on this point. Even if it was suitable, I would concur with John that to say that therapists 'cure' clients makes the assumption that the therapist is responsible for both the 'treatment' and the outcome of that 'treatment'. If this is the case, what is the client responsible for? So, John Rowan's point that the responsibility for 'getting better' is firmly with the patient is one that is well made and an important one.

What is the therapist's basic responsibility?

I would argue that the therapist is basically responsible for ensuring that her interventions and style of conducting therapy are conducive to the work that the client needs to do to promote her own 'cure', or more properly improvement, development, growth or whatever term the

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