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

*Windy Dryden is professor of counselling at Goldsmiths' College, London.*

therapist uses to describe the client getting better. Now there is a problem here and that is why I have chosen my words very carefully. Let me repeat them for emphasis: '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'.

The important thing about this statement is the fact that different clients need different 'treatments'. There is an apocryphal story about a trainee analyst who said: 'The comforting thing about psychoanalysis is that even though the patient is not improving, at least you know that you are doing the right thing'. This statement implies that as long as the therapist is practising her approach correctly, then this is the extent of her responsibility. There is the same smugness in Rowan's view that as long as the therapist is genuinely with the client, that's the extent of the therapist's responsibility. I think this is fundamentally wrong. As Arnold Lazarus has said (in Windy Dryden's *A Dialogue with Arnold Lazarus*, Open University Press, 1991) there are specific interventions for specific client problems and for a number of these problems (e.g. specific phobias, obsessive-compulsive disorder, body dysmorphic disorder amongst others) being genuinely with the client is not sufficient. In these cases I would argue that the therapist who sees her sole responsibility as being genuinely with the client (or interpreting the client's material or challenging the client's irrational beliefs or whatever) is not meeting the basic responsibility as outlined above. In such cases the therapist needs to provide the client with the specific interventions that the client needs to use in her everyday life. Now, I do agree that the therapist can't do the work for the client, but she does need to take responsibility to provide the client with the right tools. This means that the therapist needs to have a wide range of tools available or be prepared to make suitable referrals. However, the therapist cannot legitimately be comforted in the knowledge that as long as she is genuinely with the client (or whatever) then that is the end of her responsibility.

### *Is it wrong to want the client to get well?*

John Rowan quotes June Singer whose training analyst, after failing to restrain her from being exceedingly eager to achieve a successful outcome, shocked her by saying: 'You are not supposed to want the patient to get well'. Rowan is concerned that a 'desire for success can make the therapist lead or drive rather than be with the client'. Assuming that leading or driving the client is a bad thing — an assumption which other therapists would not necessarily share — I would argue that having a *desire* for success is not the problem here; rather the therapist's *dire need* for success is the problem. Failing to differentiate between a therapist's healthy desire to see the client 'get well' and her dire need for such an outcome, John Rowan, June Singer and Singer's analyst seem to encourage therapists to be indifferent about client outcome. This position leads to an overemphasis on process and an underemphasis on outcome. In my opinion, it is healthy for the therapist to want to have a good outcome because this will motivate her to discharge her basic responsibility (as outlined above) and to

be sensitive to the client's response in the real world to her efforts. The therapist who is indifferent to success may well be motivated to provide good therapy but, being indifferent to seeing the client 'get well', she will be less aware of the client's response to her efforts as these are manifest in the real world than the therapist who has a desire to see the client 'get well'. Ask yourself this question. 'Would I really want to see a therapist who said: I have no desire to see you get well, but I will be with you in the therapeutic process?"'

By all means let us confront our colleagues who have a dire need to see the client 'get well', since these are therapists who are invested in a good outcome to satisfy their own needs; but let us not look askance at therapists who want to see their clients 'get well' for the latter's own benefit. Having such a desire does not, by itself, lead the therapist to lead the client inappropriately. Having a dire need for such an outcome in all probability does.

### *'Being with' the client and the future of the client*

Much of my confusion about John Rowan's article stemmed from his failure to define what he means by 'being with' the client. Now this may be a term that everybody in the humanistic psychotherapy community understands, but I find it quite vague. How, for example, is one to distinguish between 'being with' and 'not being with' the client? 'A real psychotherapist', he says, 'has to be genuinely with the client, not with some future projection of what the client *should* be like'. Now this is confusing. Rowan contrasts a positive ('to be genuinely with the client') with a negative ('some future projection of what the client *should* be like'). But, what is the negative point here? Is it the future projection, what the client *should* be like or both? Thus, I don't understand John Rowan's position on therapeutic goals. And I need to understand it to make full sense of his position. My own view is that the issue of therapeutic goals is a complex one, but that there is nothing intrinsically wrong with being forward looking in therapy as long as one does not make demands of oneself and/or the client in relation to the client's goals.

### *Who is a real psychotherapist?*

Finally, the aspect of the article that I find most objectionable is his dogmatism. Note the following phrases: 'A *real* psychotherapist has to be genuinely with the client, not with some future projection of what the client should be like' (emphasis added). 'It . . . (John Rowan's view) seems so obvious to me, and really like the ABC of any decent or even defensible approach to counselling or psychotherapy', 'To me it . . . (i.e. to be attached to aims and the desire for success). . . *all* comes back to countertransference' (emphasis added).

Do you see the dogma in these phrases? John doesn't say things like: 'one view of . . ., 'in my opinion . . ., 'there are different views, but I believe . . .'. No, he knows who is a real psychotherapist and who is not; he knows what is decent or defensible therapy and what is not, and anyone who has a different view is wrong and needs to look at their countertransferential reactions. Isn't it ironic that a man who is so against therapists having some future projection of what the client *should* be like', has such a rigid view of what a real psychotherapist *should* be like!