# What a Tangled Web We Weave: Contextualizing Debate about 'Reparative Therapy'?[1]

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## SYNOPSIS

**Current argument about – and recent prohibitions of – 'reparative therapy' ignore a broader, deeper context. When there is something about ourselves we do not like or want, we expect choices. I explore the structure and logic of those choices from the perspective of a counsellor rooted in Person-centred practice and Experiential Focusing who is personally averse to 'pushing rivers'. Exploration daylights a powerful distinction between two radically different approaches to counselling and psychotherapy. It can then be used to expose a moral and political context that is going unregarded, for not entirely benign reasons.**


## 1 Choices

Suppose you don't like your nose.

You have options:

- 'Live with it', uneasily accepting that here's something you don't really like, but never – as it were – going nose-to-nose with the issue.
- Hire a cosmetic surgeon.
- Work to understand – to bring more fully into your awareness and experiencing – what it is about your nose that seems so wrong and why it must change. Seek to work through – to process – wherever that leads.[2]

The last may involve reconsidering a cosmetic surgeon. Or you may acquire an evolving, deepening acceptance of your nose as it is: ***That*** *nose is part of* ***this*** *organism, and the organism is* ***okay****.*

Now suppose that you don't like the way your mood shifts – the highs and lows that lack apparent cause or reason.

Again, there are choices:

- Live with it as best you can.
- Ask a physician to prescribe drugs which will flatten out those highs and lows.
- Seek a therapy which views your affective oscillation as pathological, and will work to change it.
- Get to know and, in so far as possible, understand your affective tides and what they mean for you, and to you. Seek to accept – not in the sense of beaten resignation, but in the sense of a compassionate embracing – that these shifts are as much a part of you as your nose. You can hire a therapist to help facilitate this.

Suppose, now, that your religion insists only heterosexuality is acceptable to God, and you know that

here and now you are *not* heterosexual. What are your options?

- The 'live with it' option remains open.
- Seeking drug therapy in the UK is not an option,[3] but entering 'drug cure for homosexuality' into an Internet search engine reveals that this is not so worldwide.
- Third option? Let us put it on hold.
- The final option is available. There are plenty of therapists to help you work to accept your orientation. Some will work with you towards reconciling your orientation with your conception of God.

That last option promises a hard journey if you are sure that *only* heterosexuality is acceptable to God.

Back to the *third* option, then?

If so, you will be entering the same dodgy world as pharmaceutical help inhabits. For example, in a letter to members dated 18 September 2012, the British Association for Counselling and Psychotherapy (BACP) made it plain that attempting to 'fix' sexual orientation is contrary to its Ethical Framework: 'BACP opposes any psychological treatment such as "reparative" or "conversion" therapy... based on the premise that the client/patient should change his/her sexuality.'[4]

Other bodies have issued similar statements.[5] Most recently, the BACP's *Therapy Today* magazine announced a 'Consensus against "gay cure"' by 'seven of the leading professional bodies representing counsellors and psychotherapists in the UK'. BACP presents this as a response to a direct request from the Department of Health.[6] The Consensus Statement is presented as a leaflet by the UK Council for Psychotherapy.[7]

*Quite right, too?*

Awful things are done to people because of homophobia and in the name of changing their sexual orientation. But what about compassionate, empathic accompaniment of *this* client – this particular, unique client – within the context of their reality and agenda?

*This client doesn't **want** to be gay whatever the Government and 'seven leading professional bodies' might wish and believe.*

## 2 Dimensions

There is complexity within complexity, here. 'Moral issues', 'issues pertaining to theory and practice', 'political issues', and associated controversies attach to the examples chosen. It is hazardous territory. It is also fruitful territory. The examples illuminate a distinction between ways of practising counselling and psychotherapy that cuts across the usual 'modalities' and 'counselling orientations'. Although it is not ground-breakingly original – the distinction is obvious once noticed – no-one seems to be noticing, and it is powerful.

Grounding theoretical exploration in controversy courts confusion and misunderstanding, *so why do it*? Partly because that is how I came to the distinction. Partly because the moral and political dimensions *are* so important, and the distinction – once established – affords a much-needed critical perspective on some current truisms. Although I will not always name the moral and political issues as they arise, they are an important and ever-present thread in this discussion.

It might be alleged that I have *already* strayed into questionable ethical territory by placing together choices involving 'cosmetic surgery', so-called 'bi-polar disorder', and 'conversion therapy'. I disagree.

Few counsellors and, I would imagine, even fewer humanistic practitioners would argue, for example, that someone whose cat has died must be less grief-stricken than someone whose partner has died. We know that what a person *feels* is often entirely independent of how others view a situation. Each of us inhabits a *phenomenological* reality that is unique and uniquely valid, and cats *can* be more treasured than partners.

To some, there will be no possible comparison between having a large nose, experiencing powerful affective tides, and having a sexual orientation at odds with what one thinks right. But from a *phenomenological* perspective, the suffering and anguish involved need not be dissimilar. Each involves a human being facing aspects of themselves they find unacceptable and which must, therefore, be – or have been – unacceptable within their social environment. This is 'conditions of worth territory'[8] and few things are as crippling or conducive to human misery as conditions of worth. Furthermore – given the heat and passion generated by 'reparative therapy' – it may be revealing to step back and consider each of these examples as *instance*s of the power of conditions of worth.

## 3 Dear Dr Mountford...

I want to step back in *time*, too, to the day when – as a BACP member – I received that letter presenting the new Statement of Ethical Practice. I was troubled by the letter's tone but unruffled by the contents: *Who would want to be doing such a thing anyway*? I was aware that

'reparative therapy' existed somewhere 'out there', but I had never paid much attention, and lesbian, gay, bisexual, and transgender (LGBT) clients and friends had no interest in being 'repaired'.

The BACP got me thinking: *Why* would 'reparative therapy' be so wrong? The short, simple answer, surely, is that *it cannot be done*. As the Royal College of Psychiatrists states in the UKCP 'Consensus Statement':[9] 'There is no sound scientific evidence that sexual orientation can be changed.' In other words, offering to change it is vicious fraud. But suppose that a drug or an intervention to change sexual orientation *did* exist. Would the BACP statement ever have been issued? My best guess is not. 'Reparative or conversion therapy' would be a viable, and therefore acceptable, option. Indeed, if there were a *drug* to do the job, I would anticipate it becoming recreational if not necessarily legal.[10]

I would still be uncomfortable with such therapy, and my unease would not be due to the shadow of homophobia alone. I am *already* uneasy with psychotropic drugs and therapeutic interventions that seek change prior to a full and compassionate understanding of the being and the organism involved.

*Why?*

On the day BACP's letter landed, I could have made a partial, but not a fully articulated response. When I reflected on the impossible predicament of someone convinced, for example, that their sexual orientation was unacceptable to God, it seemed to me I was obliged to go more deeply into the matter.

## 4 Glass-slipper Syndrome

As stated earlier, it can be revealing to step back from issues generating heat in favour of lower temperatures, and my reflections began with my own broad-based resistance to therapies focussed upon change. *What is **that** all about?*

It starts with 'glass-slipper syndrome'.[11]

*He* is an aspiring professional, climbing the training ladder of a well-respected company. Unfortunately, he hates his job. He comes to counselling and explains that he wants to change – enjoy the job. We explore. We find that who he is and what the job involves are a terrible fit. He insists. For all kinds of reasons, this is going to be a really good career, he must have a 'good career', and our job is to *make* him fit.

*She* is soon to be married. She doesn't love the guy – he's beginning to annoy her – but he will make a splendid husband. She must have a 'splendid husband'. She comes to counselling – the job description is to make her so that she will be happy with him.

"The BACP got me thinking: Why would 'reparative therapy' be so wrong?"

'Glass-slipper syndrome' as in Cinderella's sisters: *My foot has to fit, and if that means butchery, so be it.*

I am a terrible choice of therapist for someone in this kind of predicament, someone who insists on a reasoned course of action, despite what they are *feeling* and what their *organism is telling them*. When I ask myself *why*, the primary answer is not that glass-slipper therapy will usually lead to more pain and suffering – which is surely the case – but that it is about *who I am*.

It may initially seem irrelevant, even whimsical, but I do not like topiary. I do like Japanese gardens. Both express human ingenuity and artifice, but the former imposes an alien pattern and the latter – in my perception – works with and expresses something inherent in trees and plants, rocks and water. Topiary is not 'wrong', and Japanese gardens are not 'right'. But topiary upsets me, and Japanese gardens are *places where I like to be*.

There is a depth and intensity to these feelings which demands that I act accordingly. I must work 'with the grain' of what is. I can muster almost endless patience for a client who wishes to learn to *know* and even *love* the creature they find themselves to be – it involves a kind of unfolding, a becoming, of who they are. But there is a flipside. Although something more like glass-slipper work may be valid for some clients – as topiary will certainly stop a garden overrunning – I struggle to partake.

Few therapists I know would relish glass-slipper work, but my own aversion extends well beyond the examples

cited. Glass-slipper therapy is an extreme case of *fix-it* therapy – a term I shall soon explain – and although *fix-it* is the cultural norm in Britain, Canada and the USA, where I have clients or memberships,[12] I am highly allergic. I need an explanation more robust than a gardening metaphor.

## 5 *Fix-it* Therapy

Anyone seeking counselling and psychotherapy because of an identifiable problem or issue has broadly three options – they are recognizable from Section 1 – and *fix-it* is the middle option:

- Option one: Just live with it.
- Option two: Try to change who or what you are.
- Option three: Seek to compassionately accept and understand who and what you are, allow the experiences and feelings involved to process.

The first option – *live-with-it* – can be set aside. Although a counsellor certainly *may* find themselves supporting a client who chooses option one, someone who has got themselves to a counsellor will usually move towards one of the others. In any case, there is little more to say about the *live-with-it* option.

The second option – *fix-it* – can be pursued pharmaceutically, if prescription drugs are available, or through therapy.

The third option – *accept-it-and-process* – can involve a variety of spiritual and meditative practices as well as counselling and psychotherapy. It does promote change, but how, when, and precisely what changes will occur is subject to much individual variation. Paradoxically, perhaps, those changes are usually not the object of the practice or therapy.

If I am setting my face against *fix-it* in general, then I have hard questions to answer:

- Can the kind of deep personal preference described above possibly be a legitimate part of what guides a counsellor?
- Why do I sense that *fix-it* is a bad choice for most clients irrespective of whom they work with?

A solid answer to the second question will obviate the personal preference problem. Given that I am a 'person-centred counsellor' by initial training and by inclination, that commitment seems an obvious place to seek an answer because, well, person-centred counsellors value non-directivity so highly that we usually *are* part of the 'awkward squad'.[13]

In this case, though, the explanation is insufficient. Person-centred practice involves empathically standing alongside the client in their world, partaking sufficiently of *their* reality to know how it is for *them*. That creates a presumption in favour of *fix-it* activities favoured by the client. A person-centred counsellor refusing to follow their client has *added* need of a robust explanation.

*Does it help that the fix-it approach is not always benign?*

As the furore over LGBT clients illustrates, *fix-it* can potentially involve activities which are unrealistic, harmful to the client, ethically dubious, and any combination thereof. Responsible *fix-it* work involves repeated decisions which can be summed up as: *When do I, and do I not, facilitate a client's choice to impose change upon themselves*?

Joe,[14] who is afraid to fall asleep in the dark, pretty much has a handle on *why*, but he still struggles to do it. Joe determines to leave the lights off, night after night, and see if the fear passes away. *Is there a problem with that*? I was Joe's therapist, and although this is harsh, I could accept my client's need to fix-it.

Tasha – who probably experienced things as a child she still cannot remember, and who thinks we should be 'making her remember' – is gently but repeatedly discouraged. I foresee bad consequences.

*So far, so good*? These seem mainstream choices. But what about Winston, 'diagnosed bi-polar'? I supported and encouraged Winston's decision to refrain from pharmaceuticals. Our goal was that he learn to ride his personal roller coaster, benefiting from the highs and surviving the lows. That is not so mainstream, and it becomes even less so when I say that had Winston chosen drug therapy, I probably would not have worked as his counsellor. Many, perhaps most, therapists – person-centred included – would think drugs a reasonable recourse for my client and a legitimate accompaniment to counselling.

I am continuing to head *away* from received person-centred practice.[15] But here is another possibility: The person-centred emphasis on *actualization* and an *internal locus of evaluation* is incompatible with much *fix-it* activity.

It is. However, received person-centred practice is equally concerned with *non-directivity* and *empathic* accompaniment. Therefore, when *fix-it* is the client's choice, this incompatibility will generate *tension* for any counsellor valuing client autonomy, but it will not rule out fix-it. Instead, competing clinical demands must be balanced. This is similar to the responsive and dynamic balance between *empathy* and *congruence* required in

person-centred practice.[16]

I must fold and look elsewhere. My antipathy to *fix-it* cannot be laid at the door of person-centred theory or practice.

## 6 What Focusing Cannot – and *Can* – Do

It may be I do not need to look far. Received Person-centred counselling is certainly in tension with *fix-it* – that much heads in the right direction – and experiential Focusing grew from the same initial research and theory.[17] *Is Focusing the key*?

For sure, no one can simultaneously pursue *fix-it* activities while utilizing Focusing:

- Psychotropic drugs affect experiencing – they are intended to – and that interferes with Focusing. Timothy, who routinely uses Focusing, was prescribed a 'low dose' of amitriptyline as an antidote to a skin problem. He was assured that the dose was too low to have any psychotropic effect. Even so, seeking his 'felt sense'[18] became like trying to land a plane in dense fog without instruments.
- More subtly, perhaps, Focusing cannot be used to pursue an agenda or a specified outcome. It was developed to facilitate an unfolding of what is not yet known or realized, and this requires a preparedness to welcome whatever does unfold. Any desiderata will tend to come between the Focuser and the unfolding.[19]

In sum, Focusing is a quintessentially *accept-it-and-process* activity. *Does that also mean that a focusing-oriented therapist must eschew fix-it*?

Not necessarily. Offering Focusing to someone using psychotropic drugs is, in my experience, a waste of their time and money, but – pharmaceuticals aside – one can certainly offer other things alongside Focusing in the course of a counselling encounter. There is no principled reason why some should not be *fix-it*. Focusing is incompatible with *simultaneous fix-it* activities, but 'being Focusing-oriented' no more rules out *fix-it* than does 'being person-centred'.

Once again, Focusing is edging *towards* my own 'no fix-it' preference, but it is not *justifying* that preference. *Is it relevant that there are different ways of relating to Focusing*?

Individual Focusing practice can be placed on a continuum with these end-points:

- Focusing is done to better understand, and gain a fuller sense of, some particular aspect of one's experiencing. Once achieved, one returns to a more everyday way of being.
- Focusing is the greater part of that everyday way of being. One lives, or seeks to live, with a gentle, open, ongoing awareness of experiencing and – for some practitioners – of the body and the places within it where 'felt sense' resides. One becomes a kind of ongoing conversation between felt sensing and more cerebral processes.

Moving along this continuum feels a good thing to be doing. It feels 'right'. There is more space. Experiencing joins up better. Bad things which happened in the past are not undone, but they are less crippling. At the same time, *fix-it* solutions start to look brutal and ineffective, like glass-slipper solutions. They do not go with the grain.

That's *it*, the root of my objection to fix-it, and it is not so very far from topiary and Japanese gardens. It is a deeply personal commitment to being in the world in a particular way, and that means the personal commitment question from Section 5 *does* need answering: *Can this kind of personal preference possibly be a legitimate part of what guides a counsellor*?

What I describe is my particular experience. However, Focusing colleagues, and clients, and counsellors-in-training whom I have helped on to the continuum – particularly those who have moved some way along it – report something similar. *Accept-it-and-process* just feels like a better way of being in the world, and a better *default* position for a therapist. *How can one **not** bring that into everything one does, including therapeutic practice*? It is not like an aversion to professional sport which can be placed safely aside as a personal quirk so that it does not intrude into therapeutic relating – beside one's chair, perhaps, but not denied. Trying to set *this* aside entails *incongruent* relating. At least, it would for me. All I can do is be open about how I view matters and my way of practising counselling.

## 7 What I Am – and Am *Not* – Claiming

Focusing is not the only approach to this way of being in the world. Meditative and spiritual practices can lead somewhere similar. Person-centred practice weighted towards reliance on innate potential heads this way. Training and working as a counsellor in other traditions which emphasize bodily experiencing, authenticity and the acceptance of experiencing will tend here, too. I doubt everyone taking these journeys develops my degree of aversion to fix-it, but I would guess that, like me, they increasingly find that *accept-it-and-process* makes best sense, most of the time, and offer therapies that are

mostly accept-it-and-process.

My commitment to *accept-it-and-process* is demonstrably not a necessary consequence of either my Person-centred heritage or my Focusing practice. It feels more the other way around: Japanese gardens held my attention long before I knew Person-centred counselling. Similarly, I doubt that any other counselling tradition or approach strictly defines a position on a fix-it–*accept-it-and-process* continuum. Certainly, no tradition or approach can claim this as their unique territory or contribution. That is why I say that the *fix-it*/*accept-it-and-process* distinction cuts across orientations:

- Irrespective of how they identify themselves, counsellors and psychotherapists – and other helping professionals – will lean more heavily, and to a particular degree, towards *fix-it* or *accept-it-and-process.*

As a corollary, I also suggest that:

- For clients seeking therapy, a prospective counsellor's position in respect of fix-it–*accept-it-and-process* will be more useful information than will avowed orientation.

I want to be clear about what I am not claiming as well. People and situations are diverse. Therefore:

- I am not saying that some situations do not call for a *fix-it* response, and I am not saying that *fix-it* therapies, even pharmaceuticals, are a necessarily bad way of dealing with all concerns brought to all counsellors by all clients.

Even I sometimes take a 'quick fix-it' approach....

Suzanne stopped answering the telephone after her mother died, then stopped even turning its ring on. Towards the end of her life, mother had rung several times a day – ringing meant 'mother'.

> 'That particular sound?', I asked...
> [Long pause]
> 'Yes.'
> 'How about a really different ring-tone?'
> It worked.

Darren was coming out of a deep funk. Felt energized. Started clearing cupboards and wardrobes. Overwhelmed again by a huge pile of clothes on the bedroom floor, he slid back into inactivity and despair.

> 'Like you just can't face it all.'
> 'Yes.'
> 'Too much.'
> 'Yes.'
> We reflected.
> 'How about getting some of those "Really Useful Boxes?"', I asked. 'Put what you don't need right now in the boxes, tuck the boxes in the basement, take them out one at a time when you feel like tackling one....'

It worked.

## 8 Don't *Fix-It* – It Ain't Broke

Five years ago, the *Scientific American* reported a finding 'that one in 25 therapists would assist gay and bisexual patients attempting to convert to heterosexuality'.[20] In March, *Therapy Today* magazine announced UKCP's *Consensus Statement* condemning such therapy.[21]

That journey – from one in 25 to broad repudiation – has involved public, professional, journalistic[22] and political interest, and there have been speeches in the House of Commons.[23] But nowhere has there been a recognition that what is being argued about might be an instance of a more general problem.[24]

Consider these quotations from the UKCP's *Consensus Statement* in which references to sexual orientation and 'treatment' are replaced by a blank ('_____').[25]

- It is exploitative... to offer treatment that might 'cure'... '_____' as to do so would be offering a treatment for which there is no illness. (UK Council for Psychotherapy)
- As '_____' ... are not diagnosable illnesses, they do not require any therapeutic interventions to change them. (British Psychological Society)
- So-called treatments of '_____' create a setting in which prejudice and discrimination flourish. (The Royal College of Psychiatrists)

The chorus rejecting 'reparative or conversion therapy' insists that 'sexual orientations' fits the blank because nothing is *wrong* with someone who is not heterosexual. No 'illness', therefore nothing to *fix*.

But is this not also true of, for example, grief and bereavement? *Does grief and bereavement fit the blanks*? Does starving oneself to attain a sense of control or self-worth fit? Post-traumatic responses to unbearable stress or abuse? How about 'clinical depression'? Is it *really* an illness, or is it an adaptive response to impossible situations, a way of surviving that which is experienced as un-survivable? Are most of the increasingly medicalized expressions of emotional, psychological, and spiritual pain-and-suffering with handy labels *really* illnesses, or do *they* fit the blanks?

The mainstream says 'illness'. *Fix-it* is a contemporary norm, and sexual orientation is the exception. In the UK, the NHS keeps pushing medicalization and behavioural

therapies – a new book by Richard Layard and David Clark [reviewed in this issue – eds] adds a powerful shoulder to the trend while proselytizing for CBT.[26] In Canada, medicalization of 'mental health' and promotion of *fix-it* is inseparable from government-funded health and social services, and the ubiquitous Employee Assistance Programmes that promote short-term, manualized therapies. In the USA, health insurance schemes do similar work.

Internationally, DSM-5's controversial extension of the reach of diagnosed mental illness[27] is precisely a pressure towards *fix-it* therapies. Deeming something an 'illness' – or even simply 'not normal' – creates an immediate supposition that it *should* be fixed.[28] Although the label 'illness' might seem to absolve the person so-labelled of a painful sense of responsibility, 'illness' means 'something-is-wrong'. *That increases the pressure to get it fixed*.

If someone's so-called 'mental illness' is itself their best response to environmental conditions or – like sexual orientation – an aspect of human variation, they are now being forced into 'conditions-of-worth territory'[29] with a vengeance. They *will* face 'prejudice and discrimination'. The compassionate – arguably the only rational – response to a person struggling with the consequences of an adverse environment is to help them mitigate that environment while offering *acceptance* and help with *process*. The same goes for someone struggling with 'difference' and its consequences, and for *anyone* burdened by conditions-of-worth. *Fix-it* is just *torment-the-victim*.

Behind the push towards *fix-it* are clear *financial* and *political* interests. DSM-5 serves the health care and pharmaceutical industries. Huge pressure is exerted on North American counsellors by Employee Assistance Programs and insurance companies. And what government wishes to acknowledge the environmental basis of much depression? But exploring these dimensions goes beyond what I set out to discuss. Instead, I conclude by returning to the client postulated in Section 1 who finds their sexual orientation unacceptable to God. *How should I respond*?

I would explain that to the best of my knowledge – to the best of the knowledge of reputable people who study these things – there is no fix for sexual orientation. I would do this as acceptingly and respectfully as I can, and offer to help my client find peace with what is unchangeable. I would be in the mainstream.

Eventually, I might go on to explain my understanding of conditions-of-worth – how they can be societal, how they latch into human diversity and what we must sometimes do to survive. I might discuss the folly of *fix-it* approaches to suffering whose deepest roots are in conditions-of-worth. I would not be in the mainstream. I would be allying with a broad *accept-it-and-process* 'approach' that is an ongoing critique of that mainstream.

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## Notes

1 The title is taken from Walter Scott (1810), *Marmion; A Tale Of Flodden Field*, canto VI, XVII. Various editions of Marmion are available on the Internet. A brief, early development of some of these ideas appeared as 'Is the DSM pushing the river', in the British Columbia Association of Clinical Counselling's *Insights into Clinical Counselling*, August 2013.

2 When I write of 'process', I mean in the sense of, for example, E.T. Gendlin, Focusing, Bantam Books, New York, 2007; and E.T. Gendlin, *Focusing-Oriented Psychotherapy: A Manual of the Experiential Method*, Guilford Press, New York, 1996.

3 For example, http://www.independent.co.uk/life-style/health-and-families/health-news/bma-declares-that-conversion-therapy-for-gays-is-harmful-2016391.html.

4 The letter in question was sent from Amanda Hawkins, Chair of BACP, dated 18 September 2012, and headed 'Statement of ethical practice'.

5 For example, at http://www.nationalcounsellingsociety.org/about/code-of-ethics/the National Counselling Society's Code of Ethics, 'Delivery of Service', section 3, the last two bullet points seem to speak for most professional bodies when telling its members that:

- You must not offer counselling that offers sexual orientation change efforts (SOCE, reparative, conversion or reorientation therapy) or similar therapies by other names
- You must not offer counselling that seeks to eliminate or reduce same sex attraction in clients

The UK Association of Humanistic Psychology Practitioners, however, has nothing explicit to say on the matter.

6 Volume 25, Issue 2, March 2014, 'News' section available online at: http://www.therapytoday.net/article/show/4183/.

7 UK Council for Psychotherapy, 2nd Floor, Edward House, 2 Wakley Street, London EC1V 7LT (www.ukcp.org.uk) *Conversion Therapy Consensus Statement*. The leaflet is undated. The internet address provided for the leaflet by the BACP appears not to work, but an email to UKCP (www.ukcp.org.uk) yielded a copy.

8 Carl R. Rogers, 'The necessary and sufficient conditions of therapeutic personality change', *Journal of Consulting Psychology,* 21 (2), 1957, pp. 95–103.

9 Footnote 7.

10 The example of drugs that enhance cognitive performance seems salutary. See S. Watts, 'The dope on mental enhancement', *New Scientist*, 2839, 11 November 2011.

11 C.P. Mountford, 'Unpacking the congruence box'. *Self & Society*, 38 (4), Summer 2011, pp. 5–17; section 4, introduces the 'Glass-slipper Syndrome' (see www.counsellingpeople.co.uk/a).

12 I will not speak of what I lack first-hand experience of, but my sense is that 'fix-it' is at least the norm throughout the English-speaking world. Later in the article I will say *why* I think it is the norm.

13 In Canada and the USA, the notion 'Person-centred' has grown largely meaningless because the importance of non-directivity seems to have been lost. Jerold Bozarth seeks to rectify this in 'Nondirectivity in the theory of Carl R. Rogers: an unprecedented premise', *Person-Centered & Experiential Psychotherapies*, 11 (4), December 2012, 262–76.

14 Obviously not the name of the client, or clients, who provided this example. Similarly, the other clients mentioned are representative of genuine clinical experience, but I have never worked with people with these names.

15 Carl R. Rogers, 'The necessary and sufficient conditions of therapeutic personality change', *Journal of Consulting Psychology,* 21 (2), 1957, pp. 95–103. See the many evolving editions of D. Mearns and B. Thorne, *Person-Centred Counselling In Action, Sage*, London (4th edn, 2013). C. Purton, *Person-Centred Therapy: The Focusing-Oriented Approach*, Palgrave Macmillan, New York, 2004.

16 See Mountford (2011) in footnote 11. See also the section on 'The three conditions in combination' and particularly pp. 125–26 in Mearns and Thorne with J. McLeod, *Person-Centred Counselling In Action*, 4th edn, Sage, London, 2013.

17 A succinct account is provided by Campbell Purton, 'Focusing-oriented therapy', in P. Sanders (ed.), *The Tribes of the Person-Centred Nation*, PCCS Books, Ross-on-Wye, 2012.

18 For example, Gendlin (2007), in footnote 2.Campbell Purton has recently questioned 'whether it is helpful to think of the felt sense as a... bodily feeling', but my clinical experience is that for some of us it is, and for some of us, it isn't. Perhaps Campbell is pointing out another area of 'difference' where generalization becomes problematic. For *this* client 'felt sense' has proved a useful concept easily related to her own 'naïve' experience. See Campbell Purton, 'The myth of the bodily felt sense', in G. Madison (ed.), *The Theory and Practice of Focusing Oriented Psychotherapy: Beyond the Talking Cure*, Jessica Kingsley, London, 2014, pp. 221–32.

19 For example, Gendlin (2007) and (1996), in footnote 2.

20 Thomas Maier, (April 22, 2009) "Can Psychiatrists Really "Cure" Homosexuality?", *Scientific American*, http://www.scientificamerican.com/article/homosexuality-cure-masters-johnson/.

21 Footnotes 6 and 7.

22 For example, *The Independent* newspaper has carried an ongoing series of reports on "reparative" therapy dating back at least to 2012. http://www.independent.co.uk/news/media/advertising/tfl-bans-christian-groups-gay-cure-advert-from-london-buses-7640814.html?origin=internalSearch

23 For example, see Hansard: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131120/halltext/131120h0002.htm

24 That this has become a politicized issue, I can personally attest to. Check out a brief account of my experience at www.counsellingpeople.co.uk/tw.pdf

25 These quotations are from the list of 'soundbites' provided by the *Conversion therapy Consensus statement* (footnote 7).

26 I have not yet obtained the book, but a very interesting review appeared in *The Guardian Weekly*, 118.07.14 Richard Layard and David Clark (2014) *Thrive: The Power of Evidence-Based Psychological Therapies*. Allen Lane.

27 A trenchant and historically detailed attack upon the DSM following DSM-5 is provided by Ben Peck, "The history and tyranny of the DSM" in *Psychology Tomorrow Magazine*, August 2014 – Issue 13, http://www.psychologytomorrowmagazine.com/history-tyranny-dsm/.

28 See, for example, 'Is she a brat, or is she sick?'. *Maclean's*, '25 March', 2013. (http://www2.macleans.ca/2013/03/19/is-she-a-brat-or-is-she-sick/) http://www.nhs.uk/news/2013/08august/Pages/controversy-mental-health-diagnosis-and-treatment-dsm5.aspx. It is heartening to see a critique along these lines appearing in the popular press.

29 Section 2, fourth paragraph.