Reclaiming the Heart of Psychotherapy
Nick Totton

Increasingly for events like this I feel I prefer to wing it, to improvise in collaboration with those who have come to be part of the event. Occasionally I fall flat on my face, especially when no one wants to collaborate; but mostly it works pretty well, and at its best I think it's better than any delivery of a pre-written paper could be. In this case, however, the organisers have been clear that they want to publish the lecture – which obviously means that I have had to write it.

This hasn't been an entirely negative experience, though! It's given me an opportunity to reflect on a whole body and history of work in a way that I probably wouldn't have done otherwise. I've been involved for my whole career with what you might call the Loyal Opposition in therapy culture – fairly loyal, at least. So I've already said and written a great deal about these themes, and I am inevitably going to draw upon and even repeat some of this earlier work; in fact, I intend to take the opportunity for a sort of critical survey of what I have said previously. Or it might just turn out to be a Greatest Hits show. But either way, it's fairly soon going to start turning into a dialogue.

I've always been struck by how little attention therapy culture pays to its own history. This is in a way very odd, given how much attention we pay to our clients' histories; or then again maybe that's the point, perhaps that obsession with *personal* history creates a shadow in relation to our *collective* history – so much so that some psychodynamic trainees don't read Freud, some body psychotherapy trainees don't read Reich, and some Gestalt trainees don't read Perls. I think it's crucial to be informed by history, and I will come back repeatedly in what follows to the history of psychotherapy and counselling. In fact I'm going to start with something which combines my personal history and the history of a debate – and which also quotes from some of therapy's grandparents.

Nearly twenty years ago, in 1999, I published my first extended paper on the state of psychotherapy and counselling, in *The Journal of Guidance and Counselling* – an intervention in what was already a very hot conflict about regulation and professionalisation. The paper was called 'The baby and the bathwater: Professionalisation in psychotherapy and counselling'. As an indication of how hot that debate was, in the peer review process one respondent liked it, the other hated it. The editor used their casting vote and published it.

I began with a quotation from Carl Rogers:

> I have slowly come to the conclusion that if we did away with 'the expert', 'the certified professional', 'the licensed psychologist', we might open our profession to a breeze of fresh air, a surge of creativity, such as has not been known for years. In every area - medicine, nursing, teaching, bricklaying, or carpentry - certification has tended to freeze and narrow the profession, has

> tied it to the past, has discouraged innovation. ... The question I am humbly raising, in the face of what I am sure will be great shock and antagonism, is simply this: Can psychology find a new and better way?
>
> (Rogers, 1973, pp. 246-7)

The first two paragraphs of my paper read as follows:

> The unfortunate truth is that the primary response to Carl Rogers' question, in 1973 and now, is not so much 'shock and antagonism' as a deafening silence. Rogers (who developed the term 'counselling' because he was himself unable to get certified as a psychotherapist) is by no means the first significant figure in the field to oppose aspects of professionalisation - for example Freud vehemently objected to the medical model of psychoanalysis (Freud, 1926) which was intimately tied to professionalisation (Jacoby, 1986, p 145), while Jung said of psychotherapy that 'holding lectures, giving instruction, pumping in knowledge, all these ... procedures are of no use here' (Adler, 1976, p 534).
>
> Many eminent and well-respected contemporary figures have also expressed reactions ranging from horror to despair at what is happening to counselling and psychotherapy, both in the UK and in the USA (e.g. Heron, 1990, Lomas, 1996, O'Hara, 1997, Thorne, 1995). The opponents of headlong professionalisation have largely dominated the argument; but its proponents' strategy of what in German is called *Totschweigen* (deathly silence), combined with remorseless organisational advance, meets with continued success.
>
> (Totton, 2012a [1999], pp. 3-4)

Sadly, there is nothing here which I now two decades later think is wrong. This may be sad because I am a Grumpy Old Man who been stuck in the same viewpoint for far too long. But I believe - as I of course would – that the sadness is in the fact that the situation of therapy, if it has changed at all, has changed for the worse.

I am not assuming that you all agree with me about this claim, though I think it's likely that at least some of you at least partly do. In what follows, I intend to offer some justification for it, followed by some suggested foundations for an effective opposition which reclaims the heart of psychotherapy, and makes it central to our practice.

There has been one huge victory, of course, the abandonment of statutory regulation in 2011. I wrote about this at the time:

> The recent abandonment by the UK government of plans for the state regulation of psychotherapy and counselling is very largely due to a grassroots opposition movement of practitioners. Nearly 3000 signed an online petition against state regulation (a large number of practitioners and supporters also signed another, slightly more moderate, petition); money was raised for a challenge in the courts, where in a preliminary hearing the judge was deeply critical of the Health Professions Council (HPC), the body designated as regulator by the government; and before the full court hearing, the government announced that

> state regulation would not after all take place.
> Certainly a number of other factors contributed to this splendid result; not least the election of a Conservative government with an ideological presumption against regulation (the initial plan for regulation was made under a Labour government). The HPC also made a number of stupid and arrogant tactical errors. However, bureaucratic inertia would almost certainly have meant that the plan went through, had it not been that the government was made aware of a profound and stubborn opposition among the practitioners themselves, many of whom committed themselves to withhold compliance from a regulatory scheme.
> Perhaps the key event in the campaign against HPC regulation was the election by a landslide majority of Andrew Samuels, an opponent of HPC regulation, to the chair of the UK Council for Psychotherapy, one of the two major organisations in the field. The original intention was to use the election campaign as a platform for the argument against regulation; victory was a huge surprise, rocking the pro-regulation UKCP establishment to its foundations and demonstrating the massive grassroots antipathy to state control of our profession.
> The abandonment (at least for the time being) of state regulation needs to be seen in the context of the growing professionalisation of psychotherapy and counselling, which has inevitably led to the development of a new class of therapy oligarchs with a vested interest in installing mechanisms of command and control which they envisioned themselves operating. This class of oligarchs has suffered a double blow: first of all the state unexpectedly developed a plan for regulation which would have taken power away from the therapy organisations which they administered – and then they lost control of their own membership, who expressed a massive opposition to regulation itself.
>
> (Totton, 2012a [1999], pp. 3-4)

However, the dual approach of 'deathly silence' about alternatives together with remorseless organisational and bureaucratic advance has continued, and has had a profound impact, supported by a powerful cultural trend towards monitoring and regulation of every activity.

And this is the first point in my justification for saying that therapy is in a desperate state. Over recent years, following the general social mood, there has been an enormously powerful trend towards making the practice of therapy *safe.* This has involved lengthening trainings; making assessment and accreditation more rigorous; developing evidence based practice; collecting client assessment; elaborating complaints procedures; and much more. It has amounted to the installation upon the practice of therapy of a surveillance culture, partly external and partly internal. All with the purpose of taking the risk out of therapy.

Much of this effort, however, has been more or less a waste of time, because it is based on a complete misunderstanding of what sort of activity therapy is. Like life, therapy is inherently risky. Like people's lives, no two therapies – let alone two

therapists - are the same; and as with life, although many interesting views can be expressed about the best way to do therapy, none of them can be rigorously demonstrated to be true. Therapy is not a medical practice, but a practice of truth; hence measures of efficacy and effectiveness are at cross purposes to its project. Furthermore, internal and external surveillance is precisely what most clients are in one way or another suffering from when they arrive; to install the process within the therapy room, therefore, virtually guarantees the failure of therapy.

What I mean by calling therapy 'a practice of truth' is not, of course, that it has some sort of special access to truth; in fact, it is more or less the opposite. To quote myself again, from a talk I gave in 2004:

> In a world where politicians are seen to lie and lie without remorse or consequence, there is a great need for any source of truth. Psychotherapy is intrinsically concerned with truth and its consequences, untruth and its consequences, and how to distinguish the two. It is by no means the only such practice; but unlike science or philosophy, the truth it studies is not just rational but *emotional*. And unlike religion, for example, it also tells us, truthfully, that no truth is absolute - that truth is not singular but plural and contingent, and therefore subject to negotiation. This is perhaps the greatest realisation of modernity, a profoundly transformative knowledge: there is no absolute truth.
>
> (Totton, 2012a [2004], p. 108)

Another way of saying this is that the job of therapy is to usefully complicate things. On the other hand, the job of bureaucracies is to simplify things – not of course their own processes! –but these extremely complicated processes are designed to grind everything down to the simplest and most unambiguous. What we have been seeing for the last few decades is what happens when therapy, with all its invaluable complexities and ambiguities, is fed through the Simplification Machine. What comes out the other end is Therapy Sausage, chopped and mashed by outcome measurement, health and safety compliance, RCTs, and financialization.

The partner of the Simplification Machine is the CCTV camera. In keeping with the contemporary dissolving of privacy in our culture as a whole, the extraordinarily private processes of therapy are now subjected to surveillance and scrutiny. To oppose this scrutiny is not a simple thing: for therapy as for many other areas of life, the veil of privacy turns out to also be a veil of secrecy which has obscured many abuses. We have realised that practitioners need to be far more accountable than was previously acceptable.

But we are seeing throughout our society the price exacted by a bureaucratic version of accountability and visibility. Boxes are ticked and criteria are rigidly applied: some abuses come to light, some don't – and a lot of good, *complex* practice is criticised and punished. Therapy organisations have wholly failed to come up with models of accountability which sufficiently reflects the nature of our practice. I will come back to some of the reasons for this failure; but for now I want to emphasise that the

central way in which therapy has been wounded by surveillance is not external but *internal.* Michel Foucault said something very important about this:

> He [*sic*] who is subject to a field of visibility, and knows it, assumes responsibility for the constraints of power, he makes them play spontaneously upon himself; he inscribes in himself the power relations in which he simultaneously plays both roles, he becomes the principle of his own subjection.
>
> (Foucault, 1977: 202-3)

I believe that therapists have become, or are in danger of becoming, principles of our own subjection. In other words, we internalise the surveillance symbolised in complaints procedures and ethical codes. We feel and act as if there is a CCTV camera in the therapy room and a SWAT team of Therapy Police waiting in an unmarked van around the corner, ready to bust down the door if any breach of boundaries is committed. Actually, we feel as though the CCTV camera and the Therapy Police are *in our own head*. In the immortal words of a 70s American bumper sticker – Support Your Local Police: Beat Yourself Up.

Let's take this idea of the boundary breach, which has become an unexamined centrepiece of thinking about therapy, and rattle and shake it a little. Again, I'm drawing on work I've already done: I published an article in *Therapy Today* in 2010 called 'Boundaries and boundlessness' (Totton, 2012d), which rather unexpectedly turned out to be the most popular thing I've ever written, and hopefully also the most influential; I've since run a number of very well attended workshops under the same title.

In that article I tried to critique the concept of therapeutic boundaries, pointing out that it is both pretty recent – not really found before the 1990s – and not very deeply thought through. If you go back to the original writing on the subject, it is almost entirely about working with sexual abuse, where boundaries are clearly enormously important. However the idea has been generalised to dominate thinking about all therapeutic situations; and the original clear distinction between boundary *crossing*, which could be a good idea or a bad idea depending on circumstances, and boundary *violations*, seen as always harmful – this sensible distinction has been largely abandoned, so that boundaries have come to mean something that must never, never be questioned.

This development is very clearly to do with what I call *defensive practice*: ways of conducting therapy which focus not on what the client needs, but on how the therapist can stay safe. It's very explicit in the original wiring from the 1990s that, to quote, 'the risk-management value of avoiding even the appearance of boundary violations should be self-evident' (Gutheil & Gabbard, 1993, p 189). The 'risk' being discussed here is the risk of the therapist being sued: the authors are arguing that even boundary crossings which are justified and consistent with good care, should be avoided because they might look bad in court.

So defensive practice extends risk-avoidance from the client to the therapist. And while its most concrete form is about the avoidance of complaint litigation, its more subtle forms are perhaps even more damaging: therapists conduct themselves in such a way as to look good, to avoid self-disclosure, and to minimise their emotional vulnerability. So a situation which is already asymmetrical becomes one which is actively *unequal*: the client is asked to expose their deepest wounds, their tenderest desires, while the therapist protects their own inwardness in every way possible.

It is quite widely believed that therapy has always been like this. Freud is often caricatured – admired or attacked – as the original 'blank screen' therapist who maintains a cold remoteness. This is the Freud who in his early years lay on the floor with clients, and massaged their legs (Totton, 2002, p. 9); and who much later on gave a client a meal when he realised he was hungry (Gutheil & Gabbard, 1993, p 189), and with another client banged on the back of the couch and shouted 'You think I am too old to be worth loving!' (H.D., 1985, pp.15-16).

The truth is that there has always been a tension in therapy between more withholding styles and more involved styles – what I have called 'leaning back' therapy and 'leaning forward' therapy (Totton, 2010, p. 73). Some modalities natural attract and teach one or the other tendency, but in fact you can find people right across the modalities who prefer either one. There are good technical arguments in each direction, and the truth is that different clients at different times may need either approach, or something in between. It was in the 1950s, in the United States, that withholding was elevated to a clinical ideal – and this was directly linked both to the deeply conservative culture of the period, and to the transformation of therapy from a vocation to a profession, something which was loudly complained about at the time. In terminology I often find useful (Totton, 2011), the wildness of therapy was domesticated.

And domestication of course brought about a reaction, a rewilding –the Human Potential movement, followed in the 1960s by Radical Therapy initiatives (Totton, 2000, pp. 28-9) which directly addressed power issues in the therapy room, the ways in which a therapist who holds themselves back from emotional involvement can also hold onto power to define the situation (Totton, 2012a, 29ff). However the cycle continues: the humanistic therapy modalities which emerged in the 50s and 60s have been through their own process of domestication, and in some forms would be virtually unrecognisable to the pioneers.

This cycle is sometimes painful and irritating, but it is neither good nor bad: it just is. Nor is it confined to therapy. But like many historical patterns, it does tend to get coarser and more banal each time around the block. Marx said that history repeats, first as tragedy then as farce; and in my view the current state of therapeutic organisations in this country is not far short of farce. Many individual therapists continue to do excellent work; but more and more they are doing so in opposition to, sometimes in secret from, the major therapy organisations and institutions which take

upon themselves the right to police us. It is perhaps because they intuit this that therapy organisations put so much effort into trying to get us to conform.

I'll read the conclusion of my article about boundaries:

> Every therapeutic relationship needs to be a *relationship*: a place where two subjectivities meet, with all the difficulty and painfulness this implies, but also with a developing willingness and capacity to tolerate the other person's otherness. For a therapist to hold careful boundaries because they believe they *must*, or because they are afraid of the uncontrollability of closeness, cripples the potential for relatedness; but for a therapist to hold such boundaries as an honouring of the client's woundedness is itself relational. The only valid generalisation about relationships is that they are each unique; and therapists are artisans of relationship, co-creating one-off works with their clients.
>
> What is the opposite of being boundaried? One answer is 'unboundaried'; another is 'boundless'. Undefensive practice, I suggest, draws on a sense of boundlessness - abundance, space, attention, care. In contact with abundance, the therapist can afford to be generous on many levels; which communicates the experience of abundance to the client, perhaps allowing them to relax about life and its challenges. Yes, a practitioner who cannot offer her clients boundaries is dangerous. But a practitioner who cannot offer her clients boundlessness is useless.
>
> (Totton, 2012d [2010], pp. 69-70)

I think this comes very close to being right, but with some qualifications. That last sentence can be read as very harsh, but I honestly think it's true. However it would have been much better to write 'If *we* cannot offer our clients boundaries, we are dangerous. But if *we* cannot offer our clients boundlessness, we are useless.' Reading the passage now, using the female pronoun, as I habitually do, is open to misunderstanding; and it feels potentially blaming of the individual therapist. But I would say that by far the greater problem is with the trainings and the organisational structures which make it so hard, sometimes nigh on impossible, to approach our clients in a spirit of boundlessness.

As may be obvious, in talking about 'boundlessness' I was drawing in the associations of that word in Buddhism, which identifies the 'four boundless states' of Loving Kindness, Compassion, Sympathetic Joy, and Equanimity, which are all seen as 'friends on the way to Nirvana' which help dissolve the idea of a separate self. In other words, a boundless approach is good not only for our clients, but for ourselves. It combines empathy for both joy and suffering with an objective understanding that both must pass, since no state is permanent: this is the fourth state, equanimity or even-mindedness.

What I was arguing in the 'Boundaries and boundlessness' paper was not that boundaries should be replaced by boundlessness – still less, by boundarilessness! – but that the two need to be held in balance. In fact, when we look more deeply we

find that the two are in fact *interdependent*: a proper use of boundaries depends on our being able to use loving kindness and even-mindness to identify the true needs of the client, as opposed to our own defensive needs. Conversely, being able to come from a boundless place depends on our authentic needs for safety and appropriate reward being met by the use of proper boundaries. Undefensiveness, openness to the actual situation, is the key factor.

Near the start of this talk, I said that as with people's lives, no two therapies and no two therapists are the same; and also as with life, although many interesting views can be expressed about the best way to do therapy, none of them can be rigorously demonstrated to be true. I want to expand a bit on these statements and their implications.

When I say no two therapies are the same, I'm not talking about *therapeutic modalities* – though that is clearly true – but about what happens between a particular client and a particular therapist. Real life therapy 'in the wild', so to speak, is composed of one-time-only events. The practitioner may approach all their clients with the same therapeutic principles in mind; but how those principles unpack and express themselves in contact with each particular client is unique and distinctive. As with epigenetics, the same basic toolkit can be expressed in a huge variety of forms; and I think we all know from experience that with different clients we express ourselves as therapists in enormously different ways.

We could, if we wanted to, imagine a therapist meeting a new client and using a manual with a highly complex flow chart: 'If they say a, then I say x, if they do b then I do y...' and so on, so that, by the time the interaction has moved through several stages, some branches of the tree will have moved so far apart that there may be little apparent relationship between them. But this is of course a million miles from what the practitioner is *experiencing* as she works. If I try to track my own experience, when I am with a client I seem to enter a state of relaxed spontaneity where I am not following any programme, but allowing responses to arise in me: responses which I then sniff thoroughly before deciding whether to offer them to the client. or toss them back into the pool of information which is shaping my understanding.

This process is not, in the first instance at least, theoretically based. I am testing my response for *resonance.* When I speak certain sentences internally they ring loud and clear; others go 'Thud'. Theory only consciously comes in as one possible sort of spontaneous response: in the presence of a client I often find myself thinking about some particular concept or model, and experience tells me that this will usually, though perhaps not immediately, turn out to offer helpful insight into the client's process.

I read widely about therapy and counselling, and there are several theoretical structures which are familiar enough for me to make use of them in this way; I often

recommend to trainees and supervisees that they get to know a minimum of two models – and using more than one model of course guarantees a wide range of possible therapeutic processes. But I agree with Arnold Mindell (Mindell, 1985, pp. 8-9) that prior theory is not essential: through working accurately with a client's process and with our responses to it, we could spontaneously reconstruct any existing form of therapy. Of course, it might save time to read a few books!

My general point, though, is that every course of therapy is uniquely constructed from the encounter between a particular therapist, with all her personal history, therapeutic experience and theoretical knowledge, and a particular client, with all *her* personal history, life experience, and theories about how things work. As I have written elsewhere (Totton, 2011), the therapy room is in fact a place where not just individuals but whole *networks* encounter each other, represented by the therapist and the client – networks that extend through time and space via relationships of family, of work, of friendship and identification.

As part of this Greatest Hits tour, I'm going to quote at length from a chapter where I wrote about this.

> Individual and group are complementary, even co-created (Totton, 2011, pp 28-30; Macy, 1991). The individual cannot exist or be understood without the group/s of which it is part; likewise, the group cannot exist or be understood without the individuals who make it up. We each bring our entire relational context into the therapy room with us. ...
>
> In every therapy room, representatives of much larger groups are encountering each other. The client's family, their social networks, their political or spiritual organisations, their cultural and class groupings: all these are encountering not only the therapist's professional networks – this much we can be comfortable with - but also and more uncomfortably the therapist's family, social networks, political and spiritual organisations, cultural and class groupings. A problem or problems somewhere in the first network, we might say, has found its way to the second network, in the hope that this encounter will be helpful. But ultimately, everything is connected: client and therapist represent two points in one enormous network which has folded itself together to bring these two points into contact, in an attempt at self-healing – perhaps as one might put a burnt finger in one's mouth?
>
> This is not how we usually see things; and it is reasonable to ask how, or whether, it is helpful to do so. It is helpful, I suggest, because it encourages us to rely on the wisdom of the collective – as it manifests *in us*. In effect, we have been chosen as the right therapist for the situation - and the choice is not primarily a matter of our skill or competence, but of *where we are situated* in relation to the larger network. In a sense the networks we belong to help constitute our unconscious, or at least our preconscious. Hence there is little to be gained by trying to conceal our own personality or allegiances: these are precisely what we have to offer to the situation.
>
> (Totton, 2012e, 258-9)

This basic fact, though not the purpose of the meeting, is the same when any two people meet – it's true of you and your dentist; and the manualised approach to therapy indeed seeks to make it as similar as possible to seeing the dentist. Ironically, however, not even seeing the dentist is a fully manualised experience – there is a great deal of room for variation, for individual choice; and therapy is an activity where the individual variation *is* the work: what in dentistry might perhaps be seen as the bits around the edge of good professional practice, in therapy actually hold centre stage.

If each therapeutic encounter is, *and needs to be*, unique, then we cannot say a great deal about what should happen in general – beyond saying that it should follow the unique needs of the situation and respect the client's human rights. That doesn't mean there is no place for talking and writing about how to do therapy! But all the fascinating and exciting ideas about therapy are just that, *ideas,* not facts: interesting, sometimes illuminating and inspiring, but unprovable – when each encounter is unique, nothing can be proved.

No two clients have identical issues, and no two courses of therapy, even with the same practitioner, go in identical directions; while the goal in relation to which the effectiveness of the therapy might be assessed is often defined very differently *after* the work than *before,* by both the client and the practitioner: sometimes part of the therapy is realising that one's initial goals were misconceived. Attempts to bypass these problems by manualizing therapy are, not to put too fine a point on it, farcical. The whole quixotic effort to answer unanswerable questions about 'what works' is fuelled by accountancy, and can be rephrased as 'What is the smallest number of sessions with the cheapest practitioner that we can get away with?'

The answer to this unfortunate question depends entirely on what we think we are trying to do. Are we trying to offer someone the possibility of exploring their life choices up to now and into the future, and the thoughts and feelings that go with them, in the company of an experienced and interested partner? Or are we trying to suppress their unpleasant symptoms and get them back to work? Or – and personally I think this is probably the best choice – are we entering into relationship with them with an openness to *their* wants and needs, and a willingness to offer either our help in meeting them or a referral to someone better suited?

You may notice that I have moved from the accountancy question to a series of options addressed to the practitioner themselves. And this is very much to the point: it is becoming increasingly hard for anyone except the self-employed therapist to ask these questions and explore these options. What is noticeable is how ideology follows economics - the less money there is available for long term therapy which allows exploration in depth, the more theories pop up which justify short term work, justify manualization, treat practitioners as interchangeable so that the client's lack of choice appears unimportant. And it is not only management and commissioning bodies who

take on these convenient theories: the practitioners themselves are increasingly becoming hypnotised into believing them.

I'm starting to approach the end of the lecture part of our day together. But first I want to emphasise the enormous and in many ways negative role played in all this by therapy organisations, and in particular training organisations. So far as I can tell, the great majority of training organisations are actively misleading trainees in crucial ways.

To begin with, somehow the default role of therapists has become that of *employee.* This is quite a new thing: as little as a decade or so ago, the default position was to be self-employed. This was actually a very important factor in bringing me and many of my peers into the work: we wanted to do something worthwhile, and stay in control of our own lives. The sorts of work which I have been discussing in this talk can really only be done in private practice, where what we do with someone and how long we do it for is basically our business and no one else's. Equally, it is probably the sort of work that people who are drawn to private practice are much more likely to *want* to do: there is a very significant difference of culture between employment and self-employment.

Of course trainings do not deny the possibility of being self-employed; but as I say, more and more they assume that people are going to be looking for jobs, and this assumptions affects the way in which they are trained and the way in which they are encouraged to think about therapy. They also help to create the assumption that everyone has to be accredited by BACP and/or UKCP: this accreditation makes it far easier to get considered for any sort of therapy job, and is completely unavoidable if you want to work in the NHS.

Another factor here, by the way, is the requirement for placement training. This is not only objectionable, because it forces trainees to do unpaid work, often with clients who have complex needs; it also amounts to a conditioning in favour of generally short term, often outcome-focused, work under line management supervision. In other words it helps to create the default assumption in favour of employed work.

I talked with someone the other week who recently qualified, but whose training head told him that she was 'unhappy' about him advertising himself as a qualified therapist in their modality without signing up to UKCP. He was unambiguously qualified – but somehow she felt that only UKCP accreditation would make him a *bona fide* practitioner.

There are several reasons why signing up to the big organisations strikes me as unappealing; but perhaps the biggest one is that it means one has to sign up to their rules. These rules are described as 'ethical codes', which reveals an extraordinary ignorance about the meaning of 'ethics'. Which is the cue for another lengthy quotation from a recent chapter of mine:

> There has been an increasing tendency for discussions of so-called 'professional ethics' to actually be about rules, about laws; talking to trainees and recent graduates of trainings, most of them do this quite unselfconsciously, because they have been taught that this is what ethics *means* – essentially, avoiding getting into trouble: defensive practice. There are a number of reasons for this shift ... but there are also brutally practical issues involved – trainees, who may not even be really suited for the work in terms of personal character and life experience, are being invited to take on difficult and demanding clients, without being paid, long before they have had the opportunity to discover a meaningful professional ethics.
>
> In these circumstances, essentially financially driven, it is not surprising that trainers and supervisors resort to crude 'Thou shalt not' instructions ... in an attempt to avoid the most egregious errors that inevitably arise from this situation: the equivalent of saying 'Don't point a loaded gun at anyone' and hoping for the best. The real ethical failure, it seems to me, is in the current mode of organisation of training and therapy provision which puts trainees and new graduates in this unfair situation.
>
> However the 'Thou shalt not' approach is not restricted to this sort of context – essentially, an emergency. In one of many examples in our profession of the tail wagging the dog, it is generalised to the practice even of the most experienced. One effect of this ethical failure is that it discourages practitioners from exploring the true therapeutic value of risk ... At the same time as this ethical dumbing down is happening, however, it has become widely acknowledged that a major driving force in therapeutic change is the development of an authentic relationship between client and therapist. But how is authentic relationship possible without risk – of misunderstanding, of breach of trust, of failure? The concept of *enactment* is becoming more and more widely recognised - that past trauma needs to reappear, take flesh and blood form, within the therapy room, in order to stand a chance of being resolved (Maroda, 2002). But how can there be enactment without risk? Enactment will happen whether we are conscious of it or not, but it is far less risky when we *are* conscious and accepting.
>
> (Totton, 2016, p. 137)

At some points while preparing this talk I have worried about the title, 'reclaiming the heart of therapy'. It's perilously tempting to claim access to the 'real', 'true' essence of what psychotherapy is; I've fallen into this several times in the past, and I now try very hard to avoid it. But the more I thought about it, the more I realised that 'the *heart* of therapy' doesn't actually mean its essence, just as the heart of a person is not their essence: heart, head, guts and many other elements are all essential to the full functioning of a human being. 'The heart of therapy' refers to one essential element of psychotherapy: the element of love.

> Therapeutic practice, from a certain point of view, is an ongoing struggle by the therapist to live up to the aspirations of therapy – to become aware of and let go of her biases, judgements, wishes, demands for the client and reality to be a certain way. That's why and how being therapists, as well as hopefully being

> good for clients, is good for *us*. But the continuing paradox of therapy is that it can only be good for anybody insofar as it confronts and abandons its *intention* to be good for them. This is a corollary of the paradoxical theory of change (Beisser, 1970): not only does change happen when the client stops trying to change – it happens when the therapist stops trying to change them.
>
> (Totton, 2012f [2011], pp 73-4)

And what enables us, against all our instincts and everything we are told about what we are supposed to do, to stop trying to change our clients? The answer, I suggest, is love. The heart of therapy is love; and love is risky, to offer another person love always risks pain or even heartbreak. It also risks failure, attack and humiliation. But only by offering love, by risking committing ourselves to a relationship where we strive for truth not just about and for the client but about and for ourselves, can we hope that useful change will take place.

Freud, of all unexpected people, saw this and said this very clearly.'Essentially,' he wrote in a letter to Jung, 'the cure is effected through love' (McGuire & McGlashan, 1991, p. 9). This was in 1906; in 1907 – 110 years ago – he wrote in a published paper:

> The process of cure is accomplished in a relapse into love … and such a relapse is indispensable, for the symptoms on account of which the treatment has been undertaken are nothing other than precipitates of earlier struggles connected with repression or the return of the repressed, and they can only be resolved and washed away by a fresh high tide of the same passions.
>
> (Freud, 1907, p. 90)

Freud is of course thinking more about the client's love than the therapist's. But he wrote this at just about the time when he was starting to be aware of counter transference. My fantasy is that if he had followed up this insight instead of getting bogged down in the requirements of respectability and professional identity, he would have invented relational psychoanalysis.

I want to end with what some of you may have been feeling is missing from my talk: some clinical material. This is an example I have used before (Totton, 2012e), in the context of ecosystemic therapy. Paolo (a composite and fictionalised character) came to me because he "felt depressed". When we explored what this meant, it became apparent that what he mainly found difficult was taking action, of almost any kind. This meant that he seemed apathetic; but in fact he was anything but – inside him was a swarming, boiling crowd of impulses, each of which immediately became blocked or cancelled out by one or another injunction: Be Good, Be Nice, Look Before You Leap, Don't Make Mistakes...

The obvious approach, which might indeed have worked quite well in terms of changing his behaviour, would be to say something like: "No wonder you're depressed! Anyone would be depressed if they had that much to live up to! But you can choose to ignore those instructions, and stand up for the 'Bad' part of you, the

part that is human and makes mistakes...” - and so on. The less obvious approach, which is also certainly worth considering, would be to say: “Hmmm, yes, I see the problem – mistakes are dreadful – best to *stay completely still* and *not take any risks*” - to support the stuckness, in the hope of carrying it through to a place where it would naturally fall away.

I think, though, that each of these approaches – which of course both occurred to me – are in part a response to the dreadful uncomfortableness which stuckness creates in any reasonably empathic person, making us desperate to change the situation. Sitting with Paolo, I was very much aware of how his dilemma resonated inside *me*: of how much I am myself inhibited by similar internal messages, even if I (usually) do a better job of overcoming them.

The third course of action that I found, then, was to talk openly – awkwardly and haltingly – about the effect that his dilemma had on me; about how difficult it actually is to reconcile our own impulses with the needs of the larger groups of which we are part, and how confusing it becomes to try to work out what we do ‘really want’. (In doing this I was struggling against my own injunction to be a skilful therapist.) Where Paolo tended to submit to the group will, I tend to flout it; but neither approach is truly satisfactory.

After several false starts, where I lapsed back into subtly telling him how he should be – that is, taking the role of his inner critics – we were able to reach a place where we could together simply hold and share the pain of the situation. And from this sharing, something new was born, not only in Paolo, but in me as well: a new realisation, not just intellectual but embodied, that through accepting the genuine impossibility of wholly reconciling individual and group, together with the impossibility of separating them, the tension between the two can start to become creative, a field in which our energy might play.

Among the many groups which were being brought together through our work were British and Italians; conformers and rebels; Catholics and pagans; anarchists and socialists; gay men and straight men; cafe culture and home-based culture. All of these encounters became significant at various points in our work. I think it is a struggle for therapists to move beyond the idea that such contrasts may be significant *for the client*, and realise that they are significant *for the therapist as well*. It is very tempting to protect our own subjectivity by treating it as a neutral medium within which the client’s subjectivity is presented for examination; but this is far from the case. And by being willing to offer up our own position within the networks of culture and society to the therapeutic encounter, we set a tone of open undefensiveness which invites the client to do likewise.

There was a moment with Paolo, near the end of our work together, when we had yet again gone around the cycle of stuckness, self-accusation, rage and despair with which we were both by now so familiar. Pausing, we caught each other’s eye; and

simultaneously giggled, chuckled, snorted. ‘And so on...’, Paolo murmured. ‘And so on,’ I agreed. From that point I don’t think Paolo was ever again able to take his stuckness so seriously, or to locate it so firmly in the outside world.

I hope I have said enough today to make it clear that the work with Paolo was all about the heart of therapy: which is love. Only love can motivate us to take the risks, and to endure the suffering, on which successful therapy depends. Love motivates us in the continual struggle, which I referred to earlier, to become aware of and let go of our biases, judgements, wishes, demands for the client and reality to be a certain way.

References

Adler, G. (Ed.) (1976). *C.G Jung: Letters, Vol II, 1951-61*. London: Routledge and Kegan Paul.

Beisser, A. (1972). The paradoxical theory of change. In J. Fagan & I.L. Shepard (Eds.), Gestalt Therapy Now (pp. 77-80). New York: Harper. Online at http://www.gestalt.org/arnie.htm.

Foucault, Michel (1977) *Discipline and Punish: The Birth of the Prison.* Harmondsworth: Penguin.

Freud, S. (1909). Delusions and dreams in Jensen’s *Gradiva*. *Standard Edition*, Vol 9, pp. 7-95. London: Hogarth Press, 1959.

Freud, S. (1926). The question of lay analysis. In S. Freud, *Two Short Accounts of Psycho-analysis*. Harmondsworth: Penguin, 1962.

Gutheil, T.G. & Gabbard, G.O. (1993). ‘The concept of boundaries in clinical practice: Theoretical and risk-management dimensions’, *American Journal of Psychiatry*, 150: pp. 189-96.

H.D. [Hilda Doolittle] (1985). *Tribute to Freud*. Manchester: Carcanet Press.

Heron, J. (1990). The politics of transference. In R. House and N. Totton (Eds.), *Implausible Professions: Arguments for Pluralism and Autonomy in Psychotherapy and Counselling* (pp 11-18). Manchester: PCCS, 1997.

Jacoby, R. (1986). *The Repression of Psychoanalysis: Otto Fenichel and the Political Freudians*. Chicago: University of Chicago Press.

Lomas, P. (1996). The teaching of psychotherapy. In R. House and N. Totton (Eds.), *Implausible Professions: Arguments for Pluralism and Autonomy in Psychotherapy and Counselling* (pp 215-224). Manchester: PCCS, 1997.

Macy, J. (1991). *World as Lover, World as Self*. Berkeley, CA: Parallax Press.

Maroda, K. (2002). *Seduction, Surrender and Transformation: Emotional Engagement in the Analytic Process*. London: Psychology Press.

McGuire, W. & McGlashan, A, (eds.) (1991). Freud-Jung Letters: Correspondence Between Sigmund Freud and C.G. Jung. London: Penguin.

Mindell, A, (1985). *River's Way: The Process Science of the Dreaming Body*. London: Arkana.

O'Hara, M. (1997). Emancipatory therapeutic practice in a turbulent transmodern era: a work of retrieval. *Journal of Humanistic Psychology 37, 3*, 7-33.

Rogers, C. (1973). Some new challenges to the helping professions. In C. Rogers, *A Way of Being* (pp 235-59). Boston: Houghton Mifflin, 1980.

Thorne, B. (1995). The accountable therapist: standards, experts and poisoning the well. In R. House and N. Totton (Eds.), *Implausible Professions: Arguments for Pluralism and Autonomy in Psychotherapy and Counselling* (pp 141-50). Manchester: PCCS, 1997.

Totton, N. (2000). *Psychotherapy and Politics*. London: Sage.

Totton, N. (2002). Foreign bodies: Recovering the history of body psychotherapy. In T. Staunton (Ed.), Body Psychotherapy (pp. 7-26). Hove: Brunner-Routledge.

Totton, N. (2010). *The Problem with the Humanistic Therapies*. London: Karnac.

Totton, N. (2011), *Wild Therapy: Undomesticating Inner and Outer Worlds*. Ross-on-Wye: PCCS Books.

Totton, N. (2012a [1999]). The baby and the bathwater: 'Professionalisatiom' in therapy and counselling. In *Not A Tame Lion: Writings on Therapy in its Social and Political Contexts* (pp. 3-14). Ross-on-Wye: PCCS Books.

Totton, N. (2012b [2012]). The defeat of state regulation in the UK. In *Not A Tame Lion: Writings on Therapy in its Social and Political Contexts* (pp. 22-6). Ross-on-Wye: PCCS Books.

Totton, N. (2012c [2005]). Can psychotherapy help make a better future? In *Not A Tame Lion: Writings on Therapy in its Social and Political Contexts* (pp. 96-109). Ross-on-Wye: PCCS Books.

Totton, N. (2012d [2010]). Boundaries and boundlessness. In *Not A Tame Lion: Writings on Therapy in its Social and Political Contexts* (pp. 63-70). Ross-on-Wye: PCCS Books.

Totton, N. (2012e). 'Nothing's out of order': towards an ecological therapy. In M-J. Rust & N. Totton (Eds.), *Vital Signs: Psychological Responses to Ecological Crisis* (pp. 253-64). London: Karnac.

Totton, N. (2012f [2011]). Not A Tame Lion: Psychotherapy in a safety-obsessed culture. In *Not A Tame Lion: Writings on Therapy in its Social and Political Contexts* (pp. 71-81). Ross-on-Wye: PCCS Books.

Totton, N. (2016). The risk-taking practitioner: Implementing freedom in clinical practice. In J. Lees (Ed.), *The Future of Psychological Therapy: From Managed Care to Transformational*

Practice (pp. 135-45). London: Routledge.