Phil Tyson
PhD
PSYCHOTHERAPIST

From the Meaning of Madness to the Madness of Meaning

A History of Ideas in Counselling and Psychotherapy

SECOND EDITION · 2026

philtyson.com

From the Meaning of Madness to the Madness of Meaning:
A History of Ideas in Counselling and Psychotherapy.

Second edition

At the heart of all theories of counselling and psychotherapy is the belief that a conversation between the client and the therapist may in some way relieve the client's subjective distress. Different therapeutic movements have tried to account for the therapeutic character of conversation, and have developed theories to help structure the complex social situation of therapist-client talk. The three main approaches to therapy, psychodynamic, cognitive-behavioural, and humanistic, all developed at different times and within different social and organisational contexts throughout the twentieth century. My aim in this paper is to follow the history of the main ideas in therapy, and to link these with the development of the social arrangements for therapeutic practice, training and accreditation.

Key Words: Cognitive, counselling, psychotherapy, behavioural, Freud, Rogers, Beck, psychoanalysis, humanism, psychology.

Note to the second edition: this second edition (2026) corrects factual and typographical errors in the 2004 paper and adds brief updates where the professional landscape has changed. Otherwise the text is unchanged, so descriptions of the present refer to 2004 unless stated.

Tyson, P.J. (2026) From the Meaning of Madness to the Madness of Meaning: A History of Ideas in Counselling and Psychotherapy. Second edition (first edition 2004). https://philtyson.com/from-meaning-of-madness-to-madness-of-meaning-history-ideas-counsellingpsychotherapy.pdf

Contents

1.0 Freud, Psychoanalysis and the Profession of Psychotherapy.....3
1.1 Parapraxes and Dreams.....5
1.2 Neurotic Symptoms and Sexuality.....6
1.3 The Id, Ego and Superego.....7
1.4 Psychoanalysis in the UK.....9
1.5 The Rise of the Nazis and the Post War Development of Psychotherapy.....9
1.6 The Move to Registration.....10
2.0 Behaviourism, Cognitivism and the Profession of Psychology.....11
2.1 Philosophical Behaviourism and Behaviour Therapy.....11
2.2 The Emergence of Clinical Psychology.....13
2.3 The Rise of Cognitivism.....13
2.4 The Modern Applied Psychologist.....15
3.0 Humanism, Carl Rogers and the Profession of Counselling.....17
3.1 Rogers' View of the Person.....18
3.2 Rogers' View of the Origin of Psychological Disturbance.....19
3.3 Rogers on the Core Conditions.....21
3.4 The Emergence of the Profession of Counselling.....22
4.0 The Significance of Professional Knowledge.....24
4.1 The Meaningful Symptom.....24
4.2 The Ideology of the Scientific Method.....25
4.3 Technical Rationality.....26
4.4 The Equivalence of Outcomes.....27
4.5 The 3 x 3 March of Contemporary Therapeutics.....28
5.0 Conclusion.....29
References.....30

1.0 Freud, Psychoanalysis and the Profession of Psychotherapy.

By far the most common way of understanding madness throughout history is the notion that the person so afflicted is possessed by a spirit or a demon. Given that the main characteristic of mental health problems and the dementias is that, both to themselves and to those around them, the person does not 'seem themselves', it is logical to assume that the new behaviour should rightly be attributed to something else, the spirit or demon. The solution is to tempt, tease or command the demon to leave the afflicted person. Variations of the 'demonic' view of mental (and physical) illness are still prevalent today in, amongst other places, the Christian right.

With the intellectual revolution of the Enlightenment, demon possession as the cause of mental health problems was being replaced by more 'rational' and 'scientific' thinking. One of the first people to try to use scientific thinking to help people with mental difficulties was Franz Anton Mesmer (1734-1815). Mesmer was impressed by the discovery of electricity and hypothesised that illness was due to a problem with the patient's 'animal magnetism'.

> "Mesmer sought to cure patients by energising them by touch or by use of a special "wand", while they stood in a huge oaken bucket. He himself donned a purple robe, dressing like a magician, as he went about inducing a 'hysterical crisis'."
>
> (Stone, 1998, p. 59)

Mesmer was a highly charismatic healer who developed an enthusiastic and loyal public following. His methods, while clearly of benefit to at least a proportion of his patients, were also controversial. Indeed, if it were not for the fact that he was so sincere, it would be easy to dismiss Mesmer as a charlatan (Stone, 1998). Mesmer's medical colleagues were concerned, however, and commissioned a report in 1784 into his methods. The report concluded that the evidence in favour of 'mesmeric fluid' was inadequate and Mesmer left Paris to live the rest of his life in relative obscurity (Stone, 1998).

Although Mesmer disappeared from view, his ideas did not. As Martin (1981) points out, perhaps the investigating committee missed the point. The fact that many bodily and mental symptoms could be removed by suggestion was surely a scientific observation worthy of attention. Indeed, others continued to be impressed by Mesmer's work and his ideas were developed and refined throughout the 19th century. This process has been well documented by Chertok and de Saussure (1979) in their 'The Therapeutic Revolution, from Mesmer to Freud'. By the time 'animal magnetism' had reached Freud via Charcot, the techniques had undergone a century of intellectual refinement and had become (almost) respectable (Stone, 1998). The term 'hypnosis' was introduced by James Braid, the Scottish physician, in the mid 19th century (Chertok and de Saussure, 1979). The techniques of hypnosis, inducing a trance

and using the power of suggestion to heal, which were central to the Mesmeric method, remained, and still remains to this day, the same.

Stone (1977) has suggested that Mesmeric hypnotism was transformed by Freud under the influence of the 13th century Jewish mystic Abraham Abulafia of Saragossa. Abulafia developed a technique of k'fitsah or 'skipping' where the practitioner induces a trance and makes a conscious effort to skip from one thought to another until all thoughts disappear (Stone, 1977). Freud would have been aware of the mysticism of Abulafia both through the general Jewish culture of Vienna at the time, which had strong connections with the area of Saragossa and the Kabbalistic mystical folklore it espoused, and through his own paternal grandfather who was a Rabbi (Stone, 1977).

It appears, therefore, that the 'trance' of Mesmerism became the 'transference' of psychoanalysis (Stone, 1977). But Stone (1998) goes further arguing that

> "There are more similarities than might be expected between the therapeutic framework of Freud's psychoanalytic method – hour long sessions four or five times a week – and the Mesmerians of the early 1800's, who induced trances and routinely spent an hour with their patients – five times a week!"
>
> (Stone, 1998, pp. 60-61)

It seems then that the 'art' of psychoanalysis owes much to the intellectual climate in which Freud worked. Freud, like Mesmer before him, had tried to wrestle with the 'demon' of madness, and bring it firmly under rational scrutiny (and control). Freud's theory may be firmly rooted in scientific rationality, but his methods of working arguably owe at least as much to the spiritual and mystical climate which also surrounded him, and the refined methods of Mesmer and the 'power of suggestion'.

Despite this analysis of Freud's methods, he had great aspirations for the theory his methods were to generate.

> "Neither speculative philosophy, nor descriptive psychology, nor what is called experimental psychology … are in a position to tell you anything serviceable of the relation between body and mind or to provide you with the key to understanding of possible disturbances of the mental functions. … This is the gap which psychoanalysis seeks to fill."
>
> (Freud, 1917, p. 45)

> "Nothing takes place in a psychoanalytic treatment but the interchange of words between the patient and the analyst."
>
> (Freud, 1917, p. 41)

At one and the same time Freud wants us to believe that he has solved the Cartesian problem of 'the duality of mind and body', and that he has done so simply by having a conversation with his patients. It is true that, by working within Cartesian duality, Freud has made the most compelling and exhaustive attempt at 'filling the gap'. As will be shown below, Freud has made much of the phenomena of parapraxes, dreams, infantile sexuality and neurotic symptoms. Indeed, through the 'interchange of words', Freud inferred mental topographies and agencies which furnished the mind with a whole array of objects and rules guiding their inter-psychical relations. Psychoanalysis is, if anything, a theory of mind.

1.1 Parapraxes and Dreams.

By far the clearest and best exponent of Freud's views, however, is Freud himself. For this reason I wish to follow some of the arguments Freud made in his 'Introductory Lectures on Psychoanalysis' (Freud, 1917). This was the publication of a series of 28 lectures given at the University of Vienna during the First World War. In the lectures, Freud offers us the first comprehensive overview of his thinking during his career. The way Freud chose to enter the realms of psychoanalysis was through the phenomena of parapraxes (slips of the tongue). Freud (1917) argues that "… parapraxes are the product of mutual interference between two different intentions, of which one may be called the disturbed intention and the other the disturbing one" (p. 89). In other words, the 'disturbed' intention of what one was supposed to say is replaced by the 'disturbing' intention of what one really did say but wished one had not. Freud concludes that "… the suppression of the speaker's intention to say something is the indispensable condition for the occurrence of a slip of the tongue." (p. 93). It is within this simple argument that Freud's theory of mind can first be seen to take shape. Freud (1917) understands parapraxes as "… signs of an interplay of the forces of the mind, as a manifestation of purposeful intentions working concurrently or in mutual opposition" (p. 94) and concludes from this that, "We are concerned with a dynamic view of mental phenomena" (Freud, 1917 pp. 94-5).

It was the analysis of dreams, however, which Freud felt was his greatest achievement. Dreams, their ambiguous and often disturbing content, have been a major preoccupation for man since history began. For Freud, bringing the realms of the dream world under rigorous, empirical and scientific reason must have been highly satisfying. This is how he did it.

For Freud (1917), the ‘manifest dream content’, the things you can remember about the dream you had, is only the beginning. Like parapraxes, Freud postulated that what is dreamt and remembered is meaningful, but only in as much as what is left out. What is more significant than the manifest dream content is what Freud (1917) termed the ‘latent dream-thoughts’, that is the material which is concealed from consciousness, or even that material which the mind actively censors from consciousness. As to how we should go about bringing order to the realm of the dream world, Freud (1917) wrote…

> “We proceed with our work, accordingly, on the supposition that dreams are psychical phenomena. In that case they are products and utterances of the dreamer’s, but utterances which tell us nothing, which we do not understand. Well, what do you do if I make an unintelligible utterance to you? You question me, is that not so? Why should we not do the same thing to the dreamer – question him as to what his dream means?” (p. 129).

The ‘Royal Road’ to the unconscious is perhaps less technical than at first it would have appeared!

Freud (1917), of course, makes much of dreams. Indeed over a quarter of Freud’s ‘Introductory Lectures’ are devoted to dreams and their interpretation. Well over half the entire content of Freud’s ‘Introductory Lectures’ is devoted to parapraxes and dreams before he even starts to consider neurotic symptoms. This is a well thought out strategy for Freud because in order to deal with neurotic symptoms in the way that he wants, he needs to convince his reader of two related things. The first is his topographical model of mind. The second is the doctrine of psychical determination.

With his topographical model of mind, Freud is arguing that the mind can be divided into the part of which we are conscious, the part that we can become conscious of should we choose to do so, and the part that is not available to consciousness. Freud (1917) referred to these three parts of the mind as the conscious, preconscious and unconscious. It is the unconscious which is of most interest to psychoanalysis as it is said to contain our most basic and disturbing thoughts, desires and instincts. Although psychical events in the unconscious are not available to consciousness, they continue to impact on our mental life. It is the psychical events in the unconscious which are said to ‘cause’, that is psychically determine, parapraxes and our dream life. Indeed these are the areas where the unconscious can be inferred and studied in non-neurotic people.

1.2 Neurotic Symptoms and Sexuality.

Freud (1917) argued, therefore, that both parapraxes and dreams have a sense, that is they both can be shown to be ‘sensible’. Freud (1917), however, goes further to say, “It was discovered one day that the pathological symptoms of certain neurotic patients have a sense.

On this discovery the psychoanalytic method of treatment was founded" (p. 111). Perhaps Freud's greatest contribution was the idea that patients' despair, anxieties, obsessions, headaches, and 'irrational' fears, thoughts and dreams had a 'sense', and could be seen, after analysis, to be 'sensible' adjustments to the patients' world. For Freud, like parapraxes and dreams, the place to look for the 'meaning' to neurotic symptoms was in the unconscious mind, and in particular, Freud argued, it was unconscious sexuality that was at the heart of understanding neurotic symptoms.

> "[The] … instinctual impulses which can only be described as sexual, both in the narrower and wider sense of the word, play an extremely large and never hitherto appreciated part in the causation of nervous and mental disease."
>
> (Freud, 1917, p. 47)

In terms of the 'wider' sense of the word 'sexual', perhaps Freud's most interesting contribution was to postulate that children, as adults do, experience a 'sexual' life. For Freud, infantile sexuality both took a different form to adult sexuality, but was also its precursor. Indeed, the subject of sexuality dominated Freud's thinking from very early. Freud, in collaboration with Joseph Breuer, published 'Studies on Hysteria' (Breuer and Freud, 1895), and the following year, in 'The Aetiology of Hysteria' (Freud, 1896), he argued that the cause of his patients' illness was 'seduction' prior to puberty by an adult. This paper caused outrage amongst his peers. This notion was abhorrent to the late Victorian sensibility, an era noted for the placing of 'skirts' around the ankles of grand pianos lest they cause embarrassment to the ladies. Under intense pressure, the 'trauma' theory of neurosis (as it was called) gave way in 1897 in favour of a stage dependent view of child sexual development which did not admit 'seduction' by an adult to account for neurosis. In 1905 Freud published the case of 'Dora' in which a young woman was treated claiming to have been sexually molested. Much to Freud's dismay, Dora 'resisted' much of Freud's 'deeper' suggestions, and Freud's denial of her actual story ultimately led Dora to terminate analysis prematurely. The rejection of what we would now call 'child abuse' was Freud's biggest single professional mistake.

1.3 The Id, Ego and Superego.

While continuing to work with an increasing number of neurotic patients, Freud became dissatisfied with his earlier conceptions of the structure of the mind to explain all his patients' symptoms. It seemed to him that the model of conscious, preconscious and unconscious he had developed did not fully capture intrapsychic life. In 'The Ego and the Id' (Freud, 1923), Freud postulated that the mind may better be conceived as a structure of several 'agencies' or 'institutions'. In short, the earlier topographical model of psychic life was superseded by a structural model (Wollheim, 1973), consisting of 'id', 'ego' and 'superego'.

The id, Freud (1923) argued, is present from birth, and is the most basic, primitive, illogical and totally demanding part of the personality. The id is essentially concerned with pure survival, and with those things that give it pleasure such as avoiding pain, food and comfort. The ego, according to Freud (1923), is the second part of the personality to develop. The ego is born of the id because, as the child starts to acquire language in the second year of life, the child's parents stop giving in to all the child's demands. The id becomes frustrated and the child has to learn to be more realistic in its demands. It is the frustration of the id that gives rise to the ego in order to mitigate this frustration.

As the child continues to develop, he or she starts to learn that some of the strategies the ego could use to satisfy the id's demands are not tolerated by caregivers. For example to batter another child who is frustrating the id's demands may be a rational ego response but will usually be followed by punishment. The third part of the personality to develop, the superego, regulates the ego to make sure the ego does not use unacceptable ways of satisfying the demands of the id. As such, the superego acts like a censor, and is the strongest part of the personality by age five (Smith, 1990).

For Freud, the development of psychological disturbance requires three conditions to be present (Smith, 1990). First, there must be pronounced psychological conflict ongoing within the personality. As described above, such conflict occurs through the outburst of the demands of the id, and is usually traceable to problems in the development of infantile sexuality. Second, symptoms of neurotic illness are the result of the ultimate failure of the ego to tame the id, and hence the ego can no longer cope with the conflicts. Third, the mind of the afflicted person must try to employ some form of defence mechanism to curb the now unruly demands of the id. The id, however, continues to make itself felt through the disguised form of symptoms.

On Freud's view, defence mechanisms are essential for the perpetuation of psychological disturbance precisely because they keep conflicts outside of consciousness (Smith, 1990). Defence mechanisms naturally occupied a great deal of Freud's attention, particularly the defence of repression. However, Freud recognised many different kinds of defence mechanism as shown below.

> **Some Freudian Defence Mechanisms.**
>
> **Repression.** This is the process of dealing with disturbing memories by actively forgetting them. For example, one might 'forget' one's incestuous longing for one's mother, one's fear of castration, etc.
>
> **Denial.** This defence bars a perception rather than a memory from consciousness… For example, a person might attempt to deal with unconscious fears of his father through forming the irrational idea that he does not really have a father.

> **Projection.** Projection is the process of attributing an aspect of oneself to someone else. For example, aggressive impulses towards others might be transformed by means of projection into the belief that one is being persecuted by others.
>
> **Introjection.** Introjection is the process of unconsciously emulating someone else. A child whose masturbatory activities are severely curtailed by her parents might, for example, begin to suppress and condemn these desires herself.
>
> (Taken from Smith, 1990, p. 24)

1.4 Psychoanalysis in the UK.

In the UK, there was a very small but significant interest in Freud's ideas, with the London Psychoanalytical Society being established in 1913 (re-formed as the British Psychoanalytical Society in 1919). The British psychiatric establishment, however, remained fairly ignorant of, or indifferent to, the developments of psychoanalysis (Pilgrim, 1990). This situation was to be radically transformed between the First and Second World Wars. The first reason was due to the British State turning to psychoanalysts for explanations and treatments for 'shell shock', the phenomenon of young and otherwise healthy soldiers returning from the trauma of trench warfare (Stone, 1985). At the time, psychiatry was seen as the preserve of the seriously mad, and the government was loath to be seen as 'unpatriotic' by placing the 'war heroes' under their care. Psychoanalysis, therefore, found its way into the British health care system where it has maintained a presence ever since.

The position of psychoanalysis was further bolstered in the preparations for the Second World War when it was the psychoanalytic profession, and not the psychiatric profession, which the British State enlisted to prepare the troops for war. It was hoped that such preparations would help mitigate the traumatising effects of battle upon the soldiers (Pilgrim, 1990). It should be stressed, however, that psychoanalysts were only begrudgingly recognised within the British Medical Association (BMA) and were still treated with great suspicion (Pilgrim, 1990).

1.5 The Rise of the Nazis and the Post War Development of Psychotherapy.

Although the 'political' implications of not wanting to be seen to be placing the First World War veterans under the care of psychiatrists led to a boost in the fortunes of psychoanalysis within the British health care system, the main impetus for the spread of psychoanalytic thought world-wide can be attributed to the rise to power in the 1930s of the National Socialist Party in Germany, and the anti-Semitism of Adolf Hitler. Freud, like many of his followers, with perhaps the notable exception of Jung, was Jewish, although Freud himself was not religious. Freud, as a Jew, and Freudian ideas themselves, became under increasing threat from the National Socialist state machinery, with the result that many of the leading

thinkers in psychoanalytic thought fled from its persecution, mainly to New York or London (Pilgrim, 1990).

In New York, the establishment of psychoanalysis had a great influence on American psychology, and particularly on the development of the humanistic tradition. In London the two main protagonists were Anna Freud and Melanie Klein, though Klein had already settled there in 1926. Freud himself fled to London in 1938, but died a year later.

1.6 The Move to Registration.

With the post war adoption of psychoanalysis into medicine, there appeared a much more settled institutional base for psychoanalytic treatment. There was an almost exponential growth in training institutes for psychotherapists. Without wishing to anticipate future sections, as behavioural, cognitive and humanistic traditions of therapy evolved in the post war era, there became not just Freudian derivative institutes of psychotherapy, but an increasing number of non-Freudian institutes also claiming competence to train psychotherapists, some of which were highly dubious. Indeed, it took a branch of psychotherapy known as ‘Dianetics’, and its location within the ‘cult’ of Scientology, that finally galvanised the ‘respectable’ psychotherapy institutes into action (Pilgrim, 1990). There was much public concern about Scientology and its ‘brain washing’ techniques during the 1970s (e.g. see Foster, 1971), yet the ‘Rugby’ conference of psychotherapy training institutes did not first meet until 1982, over ten years later, to work towards self-regulation. The U.K. state showed little interest in regulating the psychotherapy profession. The Rugby Conference eventually became the United Kingdom Council for Psychotherapy (UKCP), and became the main validating body for psychotherapists in the UK. By 2004 the UKCP had over 80 member organisations, most of which trained psychotherapists. The training and accrediting organisations of the UKCP were then divided into eight sections, including: Analytic Psychotherapy; Humanistic and Integrative Psychotherapy; Family, Marital and Sexual Therapy; Hypnotherapy; Cognitive and Behavioural Psychotherapy; Psycho-Analytically Based Therapy with Children; Experiential Constructivist Therapies.

Since this paper was first written, the move to registration has taken a different course. Statutory regulation of psychotherapists and counsellors was proposed but then dropped (Department of Health, 2011). Instead, since 2013 the registers kept by professional bodies such as the UKCP and the BACP have been accredited by the Professional Standards Authority. New NHS England guidance requires counsellors and psychotherapists working in or for the NHS in England to be on the accredited register of one of five such bodies, including the UKCP and the BACP, by March 2027 (NHS England, 2026).

2.0 Behaviourism, Cognitivism and the Profession of Psychology.

The development of psychoanalysis can be clearly traced to the work of one man. Although the behavioural and cognitive approaches to therapy developed in direct opposition to psychoanalytic thought, and particularly its conceptualisation of 'unconscious' mental processes, no one single person could be said to have been influential above all others. Indeed cognitive and behavioural therapy comprises a range of insights, techniques and methods from a wide number of sources. What such approaches have in common is that they attempt to change problem behaviours, feelings and thoughts directly, without recourse to the notion of the unconscious.

The way in which cognitive behaviour therapy has developed owes much to its philosophical roots in the empirical psychology of the late 19th century and its inheritors in the 20th century of behaviourism and cognitivism. Moreover, just as Freudian psychoanalysis can be seen to be shaped by the context in which it was practised and developed, private practice with the upper middle class mildly neurotic, cognitive behaviour therapy is similarly closely tied to the development of the post war National Health Service and the development of the profession of Clinical Psychology within it. It is my aim in the next sections to chart these developments, and their impact upon modern applied psychology.

2.1 Philosophical Behaviourism and Behaviour Therapy.

The philosophical and empirical tradition of 'Behaviourism' emerged in the early 20th century. The three main protagonists were Thorndike, Skinner and Watson. Their main aim was to develop a psychology that was based only on that which could be observed. The hypothesised 'internal' conflicts of the mind, which played such an important role in psychodynamic thought, since they could not be observed directly, were given no attention. Perhaps of greatest concern to these early behaviourists was how people learn. The two major theoretical constructs to develop from 'learning theory' were classical and operant conditioning.

Classical conditioning is often attributed to the work of Pavlov (1927) and is sometimes also referred to as the 'conditioned reflex'. Pavlov studied the salivary response of dogs. He found that if he rang a bell at the same time as presenting food to the dog, then, in time, the dog would start to salivate in response to the bell even if food was no longer presented. In operant conditioning, associated with the work of Skinner (1971), behaviour is seen to be both shaped and maintained by its consequences. This approach goes beyond classical conditioning in paying attention to the environment after a response has been made. Positive reinforcers are events that occur after a response has been made that make the response more likely to occur again. Negative reinforcers are unpleasant events that are removed after a response has been

made, which also makes the response more likely to occur again. Events that make a response less likely to occur again are known as punishers (see Brewin, 1988).

The principles of classical and operant conditioning were initially investigated in animal experiments. Indeed this was a sensible strategy for a philosophy that did not wish to rely upon introspection as a basis for understanding behaviour. The newly discovered 'principles' of learning were, however, quickly applied to human subjects. In the first instance, experimenters tried to use learning theory to create and abolish behaviours in human subjects in the laboratory. Often the experimenters used children as their subjects. Perhaps the most cited of these experiments was Watson and Rayner (1920) and their case of 'Little Albert'. In this experiment a loud noise was paired with the presentation of a white rat. After a number of presentations, the child responded with fear to the rat alone. Although there are problems in generalising from animal models of conditioning to humans (e.g. see Brewin, 1988), the notions of classical and operant conditioning have been used as a basis for trying to understand human neurotic behaviour. One of the first theories of this type was Wolpe's (1958) model of phobias based on Pavlovian conditioning. Wolpe's (1958) model assumed that the fear which is characteristic of phobic states was learned in a similar sort of way to Little Albert learning to be scared of the rat, by exposure to unpleasant experiences. Wolpe (1958) went further, however, to suggest ways in which learning theory could be used as a basis for treating phobias.

Wolpe (1958) realised that it is not possible to be both relaxed and in a state of anxiety at the same time. Wolpe's (1958) treatment was first to teach the client deep relaxation, then slowly, and in a controlled way, start to introduce the object of fear, a process known as 'systematic desensitisation'. For example, if a patient had a phobia of feathers, after the patient had learnt to relax, a feather would be brought into the therapy room but kept a long way from the patient. Over several weeks the feather would be brought into closer contact with the patient until the patient was able to touch it and play with it. The phobia would then be said to be resolved. Systematic desensitisation and its variants remains an important therapeutic tool in the armoury of the behaviour therapist today.

Since these early attempts at behaviour therapy in the 1950s, many new techniques have been added, and there has been much research into its methods and practice. In particular, the claim of psychoanalysts that, by not curing the underlying unconscious problem, 'symptom substitution' would occur, has been shown to be false. Behavioural therapy has proved beyond doubt that it is not necessary to delve into the unconscious when treating a wide variety of maladies.

With the emergence of behaviour therapy, however, the relationship between therapeutic practice and its epistemological origins had become strained. As Brewin (1988) noted, some

behaviour therapists (e.g. Wolpe, 1976) have seen theory and practice as being synergistic, while the opposite view, that behavioural psychotherapy has evolved in a purely pragmatic way, has also been argued (e.g. Marks, 1982). This is an important distinction, between behaviourism, a set of loosely related ideas and precepts about the purpose and scope of psychological enquiry, and behaviour therapy, a set of procedures for eliminating or reducing symptoms and unwanted behaviours.

2.2 The Emergence of Clinical Psychology.

Until the late 1950s, British psychologists working within the NHS were mainly concerned with the administration and interpretation of psychometric tests. This work was in keeping with the strong psychometric tradition characteristic of British psychology at the time. Their work in no way could be considered therapeutic in intent, and held a traditional 'handmaiden' relationship to medicine (Pilgrim, 1990). With the development of behavioural models of neurosis, psychologists were now in a position to challenge the orthodoxies of psychodynamic psychotherapy on the one hand, and traditional nosological psychiatry on the other (Pilgrim, 1990). One man was in the forefront of this challenge, Hans Eysenck. One aspect of Eysenck's strategy for the development of a 'clinical psychology' was to challenge directly the other major psychological model operating within the health service, psychoanalysis (Eysenck, 1952).

As Pilgrim (1990) argues, "[T]he denigration of psychoanalysis and its psychotherapeutic derivatives went hand-in-glove with clinical psychology differentiating itself from medicine and marking out an area of separate epistemological validity" (p. 7). The emerging clinical psychology was perhaps on firm ground, because psychoanalysis, being a psychology of the irrational, had always sat uncomfortably with the British empirical tradition (Pilgrim, 1990). Furthermore, behavioural methods seemed to offer not only a 'rational' psychology, but one that was time limited and more cost effective than its psychoanalytic counterparts. Psychoanalysis itself was also under strong pressure from the medical profession, particularly psychiatry. Although psychoanalysis had been in the vanguard leading up to the Second World War, in the post war years, the development of the major tranquillisers had started to have an enormous beneficial impact on the treatment of patients. Politically, psychiatry was now firmly back in control (Stone, 1998).

2.3 The Rise of Cognitivism.

The history of therapy in the first half of the 20th century shows that theory was dominated by the traditions of psychoanalysis and behaviourism, both of which were, by definition, mutually opposed.

> "For one the individual's internal world was unimportant and his or her actions were determined by environmental events. For the other the internal world was all important, but its workings were unconscious and accessible only with the help of a trained guide. The thoughts which most people regarded as central to their experience of everyday life were seen by both schools as peripheral."
>
> (Moorey, 1990, p. 226)

With the 1970s came a new approach to psychology, 'cognitivism' (see Mahoney and Arnkoff, 1978). For Brewin (1988), "The main distinguishing feature of a cognitive approach to psychological investigation lies in the emphasis given to mental processes that intervene between an environmental event and the reaction of a person or animal" (p. 4). This increasing interest in the developments of cognitive psychology led to various attempts at incorporating cognitive theory into therapeutic practice. The best known attempt which has perhaps had the greatest impact is Beck's 'cognitive therapy' (Beck, 1976).

Beck was originally a psychodynamically trained therapist who, like many before him, became disillusioned with the orthodoxy of the Freudian approach. Beck became interested in depression, and, through his research, came to the conclusion that depression could be best characterised as a 'thought disorder' (Beck, 1963). This was a monumental moment in the development of therapeutic approaches in that for the first time 'cognitions', that is 'conscious thinking', for want of a better expression, the kinds of things we say to others and ourselves 'as a matter of routine or habit', were placed at the heart of a psychological theory of mental distress.

According to Beck (1963), the depressed person 'distorted' information received from their world in a negative way. Central to Beck's cognitive model of therapy was helping patients to identify and challenge these 'dysfunctional' thoughts (Beck, 1964). What is of crucial importance here is that Beck was arguing that dysfunctional emotions such as anxiety and depression were the result of the patients' perceptions and evaluations, rather than stemming from the events themselves. Effort has therefore been directed at identifying the typical ways in which people 'distort' their experience of themselves and their world. The following list is as good and as comprehensive as any.

Some Cognitive Distortions.

1. All-or-nothing thinking: You look at things in absolute, black-and-white categories.
2. Overgeneralization: You view a negative event as a never-ending pattern of defeat.
3. Mental filter: You dwell on the negatives and ignore the positives.
4. Discounting the positives: You insist that your accomplishments or positive qualities "don't count".

5. Jumping to conclusions: (A) Mind reading – you assume that people are reacting negatively to you when there's no definite evidence for this; (B) Fortune-telling – you arbitrarily predict that things will turn out badly.

(Taken from Burns, 1990, p. 77)

The cognitive therapist's role is to help the patient identify their 'faulty' thinking, and draw up strategies for changing such thinking. Standard sheets are often employed to help patients keep records of their cognitive 'distortions', and the analysis of such standard sheets forms the basis of the ongoing week by week therapeutic work.

For cognitive and behavioural approaches, various research studies in the U.S.A. and the U.K. have shown that cognitive and behavioural therapies are at least as effective as antidepressants, and synergistic with antidepressants (e.g. Rush et al. 1977, Teasdale et al. 1984). Cognitive and behavioural strategies now exist for many psychiatric problems and are even extending into areas that would traditionally be seen as medical, such as chronic pain management (e.g. see Grant and Haverkamp, 1995).

Since 2008, the Improving Access to Psychological Therapies programme, now NHS Talking Therapies, has delivered cognitive behaviour therapy on a large scale within the NHS in England (Clark, 2011). The tradition has also continued to develop, with 'third wave' approaches such as mindfulness-based cognitive therapy and acceptance and commitment therapy (Hayes, 2004), while newer methods such as eye movement desensitisation and reprocessing (EMDR) have been recommended by NICE (2018) for post-traumatic stress disorder.

2.4 The Modern Applied Psychologist.

The organisation of psychology as a professional activity started in 1901 with the formation of the British Psychological Society (BPS). In many significant respects, the history of psychology as a social activity is synonymous with the growth in the BPS. The BPS '… exists to promote the advancement of psychology and its applications, and to maintain high standards of professional education and conduct' (BPS, 1999, p. 1). In other words, the BPS is not just an organisation concerned with the development of psychology as such, but also has a major interest in the licensing of applied psychologists.

The social legitimacy of the BPS gained a huge boost in 1965 when it was granted its Royal Charter[1]. In many respects this was a most remarkable event. At the time psychology was still carving out its own epistemological validity within the health service, with Eysenck at the forefront of the behavioural tradition. Yet at the same time, within applied and experimental psychology, there was a great deal of turmoil with the introduction of the cognitive paradigm.

[1]Court, Buckingham Palace, 26/2/65.

Within clinical psychology, although postgraduate training courses were starting to appear in the 1960s, their numbers were small, and clinical psychology still did not enjoy professional autonomy from medicine. The Royal Charter reflects (if anything) the aspirations, determination and connections of its protagonists to legitimise their activities within the British establishment. Indeed, it also reflects a willingness of the British establishment to facilitate this, something it clearly lacked with respect to the development of the psychotherapy profession. The profession of psychology also received a further boost in 1987 when, under amendments to its Royal Charter, the BPS was authorised to maintain a Register of Chartered Psychologists. Never before had social scientists been allowed to refer to themselves as ‘Chartered by Royal Statute’.

Through the 1980s, as the postgraduate training courses developed and consolidated, the discipline of clinical psychology became increasingly eclectic (Richards, 1983). Some courses, particularly at the Maudsley, still retain a purist stand, but courses can now be found which incorporate cognitive, behavioural, psychodynamic and humanistic perspectives of working with clients. Modern clinical psychology can be considered nothing other than eclectic. In any event, in 1977 The Trethowan Report (DHSS, 1977), a report into the role of clinical psychology within the NHS, had recommended structural autonomy of clinical psychology from medicine. The need of the 1950s for sharp epistemological boundaries between medicine and clinical psychology was now redundant. Since 2009, practitioner psychologists, including clinical and counselling psychologists, have been regulated by statute through what is now the Health and Care Professions Council, and these titles are protected by law (HCPC, 2023).

3.0 Humanism, Carl Rogers and the Profession of Counselling.

Carl Rogers (1902-87) is perhaps the most radical and influential theorist since Freud himself. Rogers' impact on the practice of psychotherapy led to changes in the way therapy was perceived, delivered and consumed.

Rogers is located within the humanistic approach to therapy which developed, from the 1940s onwards, within the context of American academic psychology. The main idea of humanistic psychologists was to bring to their studies the value and worth of individual human beings. In this lies an implied criticism of both psychoanalysis and behaviourism where, it can be argued, this concern for the humanity of the subject had been lost. The primary aim of humanistic therapy is to help the client become more fully 'themselves', and to do this through 'empowering' them to take responsibility for their own feelings, behaviours, attitudes and actions.

Humanistic psychology had enormous impact upon how American therapists conceptualised and practised their activities, and a number of distinct 'schools' of humanistic psychotherapy developed, of which that of Carl Rogers has arguably been the most influential. Rogers, however, was not just an influential theoretical thinker, but was also a pioneer in the study and evaluation of therapy. For example, Rogers was one of the first to record therapist client talk for verbatim analysis, despite such recordings requiring the changing of recording drums every two minutes! Rogers was recognised for this aspect of his work by the American Psychological Association, who conferred upon him their Distinguished Scientific Contribution Award in 1956 and their Distinguished Professional Contribution Award in 1972 (Thorne, 1992). Rogers' career also had a broader social impact. In particular Rogers was often at loggerheads with the psychiatric profession as to whether he should be allowed (as a psychologist) to practise psychotherapy at all. On one occasion, a psychiatrist at the University of Chicago tried to have the centre Rogers was working at shut down because it was practising psychotherapy, and therefore medicine.

> "Rogers' response to such opposition from the medical profession was either to mount a blistering counterattack or to move ahead with such speed in theory, research and practice that the pre-eminence of psychologists in the therapeutic arena was indisputable."
>
> (Thorne, 1992, p. 59)

Furthermore

> "The word 'counselling' was originally used by Rogers as another cheeky strategy to silence psychiatrists who were objecting to psychologists practising psychotherapy. By simply changing the name of the activity he enabled practitioners to continue their work without any change in their situation and without any detriment to their clients."
>
> (Thorne, 1992, p. 60)

As a consequence of Rogers' stand against the psychiatric profession and his "impassioned insistence on the primary importance of the therapist's personal qualities he opened up psychotherapy to the psychology profession and contributed to development of lay therapy in general" (Thorne, 1992, p. 60).

Rogers (1980) also describes what he called the " … other struggle of my professional life" (p. 55) as being with behaviourism. Although not wishing to challenge the empirical findings of behaviourism, Rogers concluded that the difference between behaviourism and humanism was one of philosophical choice and as such cannot be settled by evidence alone (Rogers, 1980). For Rogers, 'free will' is the essence of man, and this is where he remained at odds with behaviourism and, in particular, with the work of B.F. Skinner (e.g. see Rogers, 1990).

3.1 Rogers' View of the Person.

Rogers (1966) wrote that the person centred point of view has a number of distinguishing characteristics, one of which is a concern and emphasis with the process of personality change, rather than with the structure of personality. In other words, the person centred theoretical approach is less concerned with the origin and development of personality per se than with the therapeutic process of personality change itself. With psychodynamic and cognitive behavioural approaches to therapy, the emphasis is usually quite the reverse. Psychodynamic approaches, for example, retain a fascination with working out the psychology of mind, with less emphasis on how and why therapy works. Cognitive behavioural approaches, on the other hand, seem to retain a fascination with 'measurable outcome', with less emphasis upon the nature of the human therapeutic relationship as such.

The foundation of the approach to therapy developed by Rogers is the idea of an 'actualising tendency' of organic life. For Rogers

> " . . . the behaviours of an organism can be counted on to be in the direction of maintaining, enhancing, and reproducing itself. This is the very nature of the process we call life. This tendency is operative at all times. Indeed, only the presence or absence of this total directional process enables us to tell whether a given organism is alive or dead"
>
> (Rogers, 1980, p. 118)

Thus, for Rogers, the actualising tendency is definitive of life itself. Whether he is talking about a potato trying to germinate in unfavourable conditions, or a child living in an impoverished or even hostile home environment (Rogers, 1980), Rogers sees the actualising tendency driving organic behaviour in a positive and constructive direction. Rogers writes,

> "The human organism . . . can essentially be relied upon to provide the individual with trustworthy messages . . . Left to itself this organismic self knows what it needs for its enhancement both from its environment and from other people"
>
> (Rogers, 1980, p. 117)

By "organismic" self, Rogers is referring to our real self as distinct from our self-concept, which is our representation of ourselves, to ourselves (Rogers, 1951).

3.2 Rogers' View of the Origin of Psychological Disturbance.

The question may be legitimately asked that if a human being strives to self-actualise, how is it possible that people suffer psychological disturbance at all? Rogers (1951) considers that when a baby, we are all in touch with our moment to moment experience. We know what satisfies our needs and we know what frustrates our needs. The former is perceived in a pre-linguistic sense as good, the latter as bad. In other words, young infants are in touch and in complete harmony with their organismic experience, or organismic self. With the development of language, the child learns to be an object to itself, and starts to develop what we refer to as a view of 'self' or 'I'. Children also learn that some things in life may be good or may be bad. Children learn to make value judgements about objects in the world, and this includes their emerging sense of self.

Some of these values the child experiences directly about him or herself and may be determined as valuable by the organism. Some values, and perhaps the greater, may have been taken from others, particularly parents and family members initially, but later from broader cultural influences such as schools and television. Rather than these values being experienced directly, they are 'borrowed' from others but are perceived in a distorted fashion, that is, they are perceived by the child to have been experienced directly and determined by the self. Values determined in this way are termed in person centred theory as introjected values (Rogers, 1951).

It is through the mechanism of introjection that the child starts to become alienated from organismic experience. This may also continue when the child starts to discover that its organismic experience is not valued by significant others. Rogers (1951) believes that all children instinctively experience themselves as being loveable and worthy of love. The infant, however, may experience a threat to itself when negatively valued experiences dominate the perceptual field. If a child experiences hitting a younger sibling as being organismically satisfying, the child may experience a parent's reaction of "You naughty boy"

or “You bad girl” as being threatening. Such experience presents the child with a dilemma, in that if it admits to awareness of the enjoyment and satisfaction of such behaviours, then this will be perceived as inconsistent with its self as being loved and a loveable person. Rogers suggests that a child may respond to the dilemma of holding apparently contradictory symbolisations in one of two ways. The first is to hold that “I perceive my parents as experiencing this behaviour as unsatisfying to them” (Rogers, 1951, p. 500) – an accurate symbolisation. Alternatively, a second would be to hold that “I perceive this behaviour as unsatisfying” (Rogers, 1951, p. 500) – a distorted symbolisation. If the latter is chosen, the values an infant comes to attach to experiences become quite separate from the infant’s own experiences of themselves.

Hence, in Rogers’ (1951) theory, it becomes quite clear that a child may introject values and distort their perception of reality, leading to an alienation of their organismic experience. Eventually, the frame of reference for evaluating its behaviour, and its self, are given over to parents and other authority figures. Primary experiences and feelings are ignored. A self concept emerges which is organised around a complex perception of self which contains only those elements about self which can be admitted to consciousness. Any stimuli which do not conform to the child’s view of self will be denied access to consciousness. The mechanism of denial, therefore, operates to protect the emerging, but organismically inauthentic, sense of self (Rogers, 1951).

Usually, however, most people cling to at least some shreds of self-esteem. Their sense of worth, however, is conditional upon winning approval and avoiding disapproval. This means, of course, that their repertoire of behaviours becomes extremely limited to those they feel are acceptable to others. In other words

> “They are the victims of the ‘conditions of worth’ which others have imposed upon them, but so great is their need for positive approval that they accept this strait-jacket rather than risk rejection by trespassing against the conditions set for their acceptability.”
>
> (Mearns and Thorne, 1988, pp. 7-8)

In the person centred approach, a person with internalised conditions of worth and a poor self-concept is characterised as being divorced from their organismic self, or ‘real’ selves. People who have lost trust in the promptings of the organismic self may develop a self-concept which, for example, may result in them saying something like ‘I am a person who never gets hurt’. In trying to protect a positive self image, those surrounded by people who are critical and judgmental may have to resort to a range of strategies in order to maintain approval. In most cases this is a progressive alienation from the organismic self. In particular, there may be a reliance on external frames of reference for guidance, including the

counsellor, and trying to please everyone often leads to unpredictable, inconsistent and incongruent behaviour.

Once this process has become part of the person's life, and the person is almost completely estranged from their organismic self, such disturbance is very likely to maintain itself. Often, this 'way of being' can be maintained for many years, and only reveals itself as an inadequate adjustment to life when a traumatic event serves to cripple the person, and their carefully constructed self-image is not capable of serving new circumstances (Rogers, 1951).

The psychologically healthy person, in contrast, is characterised by a person whose self-concept and organismic self significantly overlap (Rogers, 1951). This is someone who can trust his or her promptings from their organism, at least to a significant degree. Such 'fully functioning persons' (Rogers, 1963) are open to experience without feeling threatened and are consequently able to listen to themselves and to others. They are aware of their feelings, and can live in the moment. This expresses itself in decision making by the person being able to trust in themselves, rather than searching for guidance from other people. Rogers (1963) has described this self-referent as the locus of evaluation.

3.3 Rogers on the Core Conditions.[2]

Rogers (1990) wrote, "I have long held that it is not the technical skill or training of the therapist that determines his success . . . [but] I believe it is the presence of certain attitudes in the therapist, which are communicated to, and perceived by, his client, that effect success in psychotherapy" (p. 10). These attitudes are:

> "First, and most important, is the therapist congruence or genuineness – his ability to be a real person with the client. Second is the therapist's ability to accept the client as a separate person without judging him or evaluating him. It is rather an unconditional acceptance – that I'm able to accept you as you are. The third condition is a real empathic understanding . . . to find that here is a real person who really accepts and understands sensitively and accurately perceives just the way the world seems to me – that just seems to pull people forward"
>
> (Rogers, 1975, p. 4)

Rogers repeatedly stated his belief that these three core conditions, empathy, unconditional positive regard and congruence, were both necessary and sufficient conditions for therapeutic personality change. The most fundamental observation of these conditions is that they focus upon the quality of the relationship between therapist and client. In other words, it is the

[2]Rogers often talks about three core conditions, but in his paper "The necessary and sufficient conditions of therapeutic personality change" (Rogers, 1957) he lists six conditions in total. Different trainings in the Person Centred approach place different emphasis on either the three or the six conditions. For simplicity, I will not explore Rogers' six conditions here.

relationship itself which is seen as therapeutic, rather than any techniques or interventions per se.

3.4 The Emergence of the Profession of Counselling.

Since the 1940s, when the humanistic psychologists started to develop their thinking, there was little place for their ideas in British culture. This was not changed until the liberal upheavals of the 1960s and early 1970s (Pilgrim, 1990). In Britain, the agenda had been between psychoanalysis on the one hand and behaviourism on the other. Specifically with respect to person centred theory,

> "[a]lthough the influence of Rogers percolated spasmodically into Britain in the post-war years – mainly through the work of the Marriage Guidance Council (now known as 'Relate') and then often in an unacknowledged form – it was not until the mid-1960s that he came to be studied in depth in British Universities"
>
> (Thorne, 1990, p. 106)

The first courses tended to be for school counsellors, initially at the Universities of Keele and Reading, and were largely taught by visiting American academics. By the mid 1970s, however, there were signs that person centred counselling was moving significantly into areas other than education (Thorne, 1990).

Currently the person centred approach to counselling can be studied in hundreds of colleges of further and higher education. Furthermore, there are many courses in person centred counsellor supervision and training. Many of the courses available in the further education sector are part time, as well as full time and/or modular. Person centred courses, therefore, tend to be the most accessible of all theoretical approaches, and are most inclusive of people from all backgrounds. This contrasts with both psychotherapy training, which is expensive and often graduate entry, and clinical psychology, which requires a good psychology degree and acceptance on an NHS funded training course.

The BACP[3] was founded in 1977 as a professional body for the development of counselling. In the early 1990s it started to accredit training courses and by 2004 there were upwards of 50 accredited courses in the UK. In 1997, the BACP, in conjunction with three other counselling organisations, started the United Kingdom Register of Counsellors, a national register of counsellors who meet specified professional criteria.

As for the developments of counselling within psychology, these are most intriguing. In March 1994 the Division of Counselling Psychology was created, with appropriate regulations for the election of members to become 'Chartered Counselling Psychologists'. Interestingly the NHS has agreed to employ persons so designated on the same terms as

[3]As the British Association for Counselling.

clinical psychologists. The difference with clinical psychologists is that counselling psychologists are specially trained as therapists. They are required to have worked and been trained in at least two theoretical models, and have had experience counselling individuals, couples and groups. Clinical psychologists have a much broader remit including other areas of applying psychology to health care, and the time devoted to their training ‘as a therapist’ is consequently much less than any of the other ‘therapeutic professions’ described here. In 2004 the Counselling Psychology profession had only about 300 members, and practitioner doctorates in counselling psychology were slow to develop, due no doubt to the lack of funding such courses attract. Given that the BPS is a late player in the accreditation of specifically designated therapeutic professionals, it seems that the BPS has designed the ‘Chartered Counselling Psychologist’ to be the expert above all experts in the field of counselling and psychotherapy. Time will tell. What is of most interest here, however, is that the new profession of ‘Chartered Counselling Psychology’ has been designed to be eclectic.

4.0 The Significance of Professional Knowledge.

> "That the symptom has meaning, if it is neurotic, is Freud's basic discovery, the basic insight which opened up the way to an understanding of functional illness and the principles of psychoanalytic treatment. It is not surprising that, in the excitement of so great a discovery and one that opened up such vast new territories, Freud should have overlooked the logical implications for theory of the step he had taken. Those implications are, however, very great, for in the mechanistic medicine of Freud's time, as in all organic medicine of our own day, the symptom is logically regarded as a fact and a fact is regarded as the product of causes. In this, medicine simply follows the practice of chemico-physical science and the canons of thought which are exemplified with special clarity in physics. In discovering that the symptom has meaning and basing treatment on this hypothesis, Freud took psychoanalytic study of neurosis out of the world of science into the world of the humanities, because a meaning is not the product of causes but the creation of a subject."
>
> (Home, 1966, p. 42)

By the end of the 19th century, the science and practice of medicine had come to monopolise the understanding and treatment of madness. By taking the view that madness was a natural biological category, the twin professions of psychiatry and neurology were in the vanguard of the 'diagnosis' and 'treatment' of the new 'illnesses'. Since pathological biological processes cannot be said to be 'meaningful' (other than in biological terms), medicine rescued the insane from the moral responsibility for their own condition implied by religion. This approach yielded some notable successes. The 'insanities' of what we now call Parkinson's disease and Alzheimer's disease, for example, have clearly been shown to be organic disease processes. The organic aetiologies of other maladies, however, such as depression and schizophrenia, are, of course, still highly contested.

As I documented earlier, the 20th century witnessed a further revolution in the understanding of madness. The 'medical model' of madness was challenged by the numerous emerging 'psychologies' and their search for the rational basis for the understanding of man. It is ironic that by the time Freud (1917) was able to put forward his first comprehensive account of the meaning of symptoms, psychoanalysis had already become a deeply fragmented discipline. Freud split with two hitherto close collaborators, Alfred Adler (1870-1937) in 1911 and Carl Gustav Jung (1875-1961) in 1913. The splits were to be irreconcilable.

4.1 The Meaningful Symptom.

What is perhaps of most interest about the split with Adler and Jung is that what was at issue was the meaning of symptoms themselves. Adler seemed much more concerned to concentrate upon the meaning of neurotic symptoms as being about the unattainable goal of personal superiority, the need for power, and the excuses why such goals are never reached. Jung, on the other hand, saw the sense of neurotic symptoms as emanating from the

‘collective unconscious’, archetypes and the need for individuals to ‘individuate’ (Pilgrim, 1990). The fundamental principle of Freud’s talking therapy, that the symptom had meaning, was not challenged by either man. What was challenged was that the meaning of symptoms was to be found only in childhood sexual development. The transition of psychoanalysis into social science was most evident by these moves. Moreover the rest of the history of counselling theory can be seen as a continuation of just this debate: what do symptoms mean? For no other reason this puts Freud at the apex of modern therapeutic thought.

As I showed earlier, as psychoanalysis itself continued to fragment after Freud’s death, the meaning of symptoms was also strongly challenged from another source: academic psychology and the reactionary epistemologies of behaviourism, cognitivism and humanism. What the psychoanalysts and psychologists all sought was the elusive: to explain and account for patients’ suffering in psychological terms. Freud’s basic insight, that symptoms had meaning, was the fundamental orienting ideology that drove all the new theoretical movements. The paradox of therapy theory building since Adler’s and Jung’s splits with Freud is that, given therapy is centrally concerned with helping clients make sense of their suffering, what patients’ suffering means is the central axis around which therapists continue to disagree.

4.2 The Ideology of the Scientific Method.

Of course the 20th century was characterised by a rise of various social sciences and competing attempts to place themselves on a firm epistemological footing. With respect to the three main traditions of therapy outlined above, however, what is clear is their respective commitment to different kinds of epistemological positivism. They all ‘believed’ their epistemology was ‘scientific’, and then pursued their ‘scientific’ aspirations in their unique but disparate ways. Each of the main three traditions of therapy conceived of their task in ‘scientific’ terms. Each of the three main traditions of therapy, however, conceived of their scientific obligations differently. I will consider each in turn.

For psychoanalysis, the methods of scientific investigation and the methods of therapeutic intervention are the same thing. The ‘scientific’ methods of revealing the unconscious mind of the patient through free association, dream interpretation, analysis of the transference, etc., provides the raw material for the development of psychoanalytic theory itself. The product of the deliberations of psychoanalytic thought is a grand theory of mind, one that attempts to elucidate the structure of the mind, together with an understanding of its development, disturbance and cure.

Behaviourism and, indeed, cognitivism in its wake, conceived of their ‘scientific’ project in quite different terms. In this tradition, research is taken from experimental psychology and used to generate models of human problems. Such models are then tested in the laboratory

and in clinical settings and the findings used to develop and constrain clinical theories and methods and, in so doing, generate further questions for empirical study. The products of cognitive behavioural thought are numerous theories of discrete kinds of problems and a collection of empirically tested strategies for their treatment.

For both psychoanalysis and cognitive behaviour therapy, the 'scientific method' is used to generate models of human problems that are tested in the consulting room. Although person centred therapy does have a model of psychological disturbance, it is a generic model, applicable to all client groups. Indeed, person centred theory of clients' problems might better be conceived of as a philosophy of the kinds of problems people have, something that is intrinsically incapable of empirical refutation. Where the person centred approach does have a commitment to scientific rationality is in the understanding of personal change in therapeutic encounters. Indeed, the person centred core conditions of therapeutic personality change, congruence, empathy and unconditional positive regard, are perhaps the most researched of all therapeutic concepts.

4.3 Technical Rationality.

My concern here is not so much to highlight the divergence in thinking in the conceptualisation and execution of the different research agendas of the different therapeutic traditions, but rather to highlight a particular kind of convergence which the commitment to the 'ideology of the scientific method' has had. What I wish to draw attention to is that in following the doctrines of positivism, a new literature, or body of knowledge, has emerged. Furthermore, this body of knowledge has been created and shaped by the intelligentsia, most notably in the emerging social sciences departments of the new universities of the late Victorian era and beyond. In this sense, the commitment to positivism in therapy has created a 'knowledge rich' class of academics (Schön, 1983) whose job it is to pass this knowledge down to the practitioners of the various therapies who, in turn, are required to apply this knowledge in their clinical practice.

The difficulty for Schön (1983) with the development of the knowledge based professions is that the theory as handed down from the academy is usually insufficient to account for all the problems of routine everyday professional practice. The knowledge we need to perform our professional duties is often not represented in the theory as stated. As Schön (1983) argues, "[w]e are bound to an epistemology of practice which leaves us at a loss to explain, or even to describe, the competencies to which we now give overriding importance" (p. 20). Perhaps this is nowhere more true than in the field of counselling and psychotherapy. The theory as handed down from the academy, on its own, in no way prepares anyone for the practice of therapy. Reading Freud would not tell us how to respond to someone overwhelmed with grief. The cognitive behavioural literature would not instruct us in how to cope with our

feelings when a client is bent on taking their own life. Furthermore, person centred theory would not be in a position to help us cope with a client who was threatening to hit us. In other words, the routine and everyday experience of 'doing' therapy is not captured in the espoused 'rational' schemes of therapeutic thought as handed down to practitioners. There is a theory-practice gap (Schön, 1983). In this sense, the commitment in therapy to the ideology of the scientific method has also unwittingly created a commitment to the same kind of 'technical rationality' shared by every other knowledge based profession. The result is a range of epistemologies of therapy unable to describe what is done in their name.

4.4 The Equivalence of Outcomes.

Despite this titanic inability to agree about how people who are suffering should be best helped, the business of therapy continues unabated. Ultimately unresolved questions of epistemology and theory have not hindered therapists' ability to practice. It is my concern now briefly to ask the question if any one approach to therapy has been shown to be more effective or useful than any other. Are psychodynamic therapists any better than either cognitive behavioural therapists or humanistic therapists?

Fortunately studies to identify any such differences are voluminously produced and regularly reported in Behaviour Therapy, Behaviour Research and Therapy, Journal of Consulting and Clinical Psychology, Journal of Counselling Psychology, Archives of General Psychiatry and Cognitive Therapy and Research, to name but a few sources (e.g. see Barkham, 1996 and Saunders, 1999 for reviews). Such individual research papers are also regularly meta analysed. One such analysis is typical. Wampold et al. (1997) selected studies published between 1970 and 1995 comparing two or more bona fide psychotherapies and concluded that all bona fide therapies have similar effectiveness. Later reviews have broadly supported this conclusion (Wampold and Imel, 2015). Although there is a perennial debate about what constitutes a good therapy outcome research protocol, it appears that therapy, on the whole, does 'work'. It is also a clear and ongoing finding that, generally speaking, whatever it is that makes therapy effective, the choice of therapeutic theory the therapist has trained in is not an important factor. Indeed, as early as the 1950s evidence started to gather which seemed to demonstrate that the therapeutic qualities of counselling relationships are, in fact, qualities of the counsellors themselves, and unrelated to the trappings of counselling technology, such as theoretical frameworks, technical terms, and techniques with which professionals surround themselves (Fiedler, 1950a,b; Seeman, 1954; Parloff, 1961; and Rogers, 1962). Research also seems to suggest that in certain circumstances trained therapists differ in effectiveness from amateur helpers to no significant degree (e.g. Berman and Norton, 1985). More recent research on 'therapist effects' continues to suggest that who the therapist is makes a real difference to outcomes, more so than theoretical training (Wampold and Imel, 2015; Johns et al., 2019).

The conclusion that any theory will do, and not having a theory at all may even be preferable, has been available for some time. It has long been known as the “Dodo” verdict (Rosenzweig, 1936; Luborsky et al., 1975; Holmes and Lindley, 1989), named after the bird in ‘Alice in Wonderland’ which proclaimed, “Everybody has won, and all must have prizes.”

4.5 The 3 x 3 March of Contemporary Therapeutics.

What my earlier analysis of the history of therapy shows, however, is that the epistemological boundaries between the differing therapies were also the battle lines as the different professions vied with each other (and medicine) for the right to practice and receive status, etc. What is of more interest is that as the 20th century moved into its later decades, and the therapeutic professions became more established, the need for the maintenance of sharp epistemological boundaries started to disappear. Now all three main therapy organisations accredit practitioners of all three approaches to counselling. All theoretical positions within therapy are therefore practised by accredited therapists of any of the three main organisations. This I would characterise as the 3 x 3 march of contemporary therapeutics: three professional bodies each validating practitioners of the three main therapeutic traditions. Consequently, there is no meaningful sense anymore in which the theory of therapy is seen as being ‘owned’ by any one particular therapeutic profession. This convergence has since been formalised: the SCoPEd framework, published in 2022 and since adopted by the BACP, UKCP, British Psychoanalytic Council and three other professional bodies, sets out a shared set of competences for counsellors and psychotherapists (SCoPEd Partnership, 2022).

At the turn of the 21st century, therapists are more willing than ever to learn from each other to the point that ideas concerning the integration and the eclectic sampling of theory have formed the predominant theoretical debate (e.g. see Clarkson, 1996 and Palmer and Woolfe, 1999). Of course, there are insurmountable philosophical problems in trying to sample eclectically or integrate theoretical positions developed from the great, but diametrically opposed, social philosophies of the 20th century. Indeed Laungani (1999) has characterised the state of theory in the therapeutic professions as “epistemological anarchy” (p. 125). It is difficult not to draw the conclusion that therapeutic theory building has today become like a horse designed by committee, that is to say, a camel.

5.0 Conclusion.

In this paper I have charted the rise of the main three approaches to counselling and psychotherapy. What becomes clear from this analysis is that espoused epistemology has had as much to do with inter-professional rivalry as with the detached pursuit of truth. What is perhaps reassuring about this is that the choice of espoused theory appears to matter little in helping clients make sense of their suffering. Any theory seems to do. The challenge for the industry is to account for why this might be the case.

References.

Barkham, M. (1996) Quantitative Research on Psychotherapeutic Interventions: Methodological Issues and Substantive Findings across Three Research Generations. In Woolfe, R. and Dryden, W. Handbook of Counselling Psychology. Sage: London.

Beck, A.T. (1963) Thinking and Depression: 1. Idiosyncratic content and cognitive distortions. Archives of General Psychiatry. 9, pp. 324-33.

Beck, A.T. (1964) Thinking and Depression: 2. Theory and therapy. Archives of General Psychiatry. 10, pp. 561-71.

Beck, A.T. (1976) Cognitive Therapy and the Emotional Disorders. New York: International University Press.

Berman, J.S. and Norton, N.C. (1985) Does professional training make a therapist more effective? Psychological Bulletin. 98, pp. 401-407.

BPS (British Psychological Society) (1999) General Information about the Society. Leicester: BPS.

Breuer, J. and Freud, S. (1895) Studies on Hysteria. Published in translation by Pelican Books 1973.

Brewin, C.R. (1988) The Cognitive Foundations of Clinical Psychology. Lawrence Erlbaum Ass. Ltd.: London.

Burns, D.D. (1990) The Feeling Good Handbook. Plume: N.Y.

Chertok, L. and de Saussure, R. (1979) The Therapeutic Revolution from Mesmer to Freud. New York: Brunner/Mazel.

Clark, D.M. (2011) Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. International Review of Psychiatry. 23, pp. 318-327.

Clarkson, P. (1996) The Eclectic and Integrative Paradigm: Between the Scylla of Confluence and the Charybdis of Confusion. In Woolfe, R. and Dryden, W. Handbook of Counselling Psychology. Sage: London.

Department of Health (2011) Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers. Cm 8008. London: The Stationery Office.

DHSS (Department of Health and Social Security) (1977) The Role of Psychologists in the Health Service, Trethowan Report. London: HMSO.

Eysenck, H.J. (1952) The effects of psychotherapy: an evaluation. J. of Consulting Psychology. 16, pp. 319-24.

Fiedler, F.E. (1950a) A comparison of Therapeutic Relationships in Psychoanalytic, Non directive and Adlerian Therapy. J. Consulting Psychology 14, pp. 436-445.

Fiedler, F.E. (1950b) The Concept of an Ideal Therapeutic Relationship. J. Consulting Psychology 14, pp. 239-245.

Foster, J.G. (1971) Enquiry into the Practice and Effects of Scientology. London: HMSO.

Freud, S. (1896) The Aetiology of Hysteria. In Strachey, J. (Trans.) The Standard Edition of the Complete Psychological Works of Sigmund Freud. 3, pp. 187-221. Hogarth Press and the Institute of Psychoanalysis: London.

Freud, S. (1917) Introductory Lectures on Psychoanalysis. Published in translation by Pelican Books 1973.

Freud, S. (1923) The Ego and the Id. In The Essentials of Psychoanalysis. pp. 439-483. Pelican Books 1986.

Grant, L.D. and Haverkamp, B.E. (1995) A Cognitive – Behavioural Approach to Chronic Pain Management. J. of Counselling and Development. 74 pp. 25-31.

Hayes, S.C. (2004) Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. Behavior Therapy. 35, pp. 639-665.

HCPC (Health and Care Professions Council) (2023) Understanding the regulation of psychologists. London: HCPC. https://www.hcpc-uk.org/news-and-events/blog/2023/understanding-the-regulation-of-psychologists/

Holmes, J. and Lindley, R. (1989) The Values of Psychotherapy. Oxford University Press.

Home, H.J. (1966) The Concept of Mind. Int. J. Psycho-Anal. 47, pp. 42-49.

Johns, R.G., Barkham, M., Kellett, S. and Saxon, D. (2019) A systematic review of therapist effects: A critical narrative update and refinement to review. Clinical Psychology Review. 67, pp. 78-93.

Laungani, P. (1999) Danger! Psychotherapist at work. In Counselling Psychology Quarterly 12, pp. 117-131.

Luborsky, L., Singer, B. and Luborsky, L. (1975) Comparative studies of psychotherapies: Is it true that “everyone has won and all must have prizes”? Archives of General Psychiatry. 32, pp. 995-1008.

Mahoney, M.J. and Arnkoff, D.B. (1978) Cognitive and self-control therapies. In S.L. Garfield and A.E. Bergin (Eds.) Handbook of Psychotherapy and Behaviour Change. 2nd Edition. Wiley: New York.

Marks, I.M. (1982) Cure and Care of Neurosis: Theory and Practice of Behavioural Psychotherapy. New York: Wiley.

Martin, B. (1981) Abnormal Psychology – Clinical and Scientific Perspectives. Second Edition. Holt, Rinehart and Winston.

Mearns, D. and Thorne, B. (1988) Person-Centred Counselling in Action. Sage: London.

Moorey, S. (1990) Cognitive Therapy. In Dryden, W. (Ed.) Individual Therapy – A Handbook. pp. 226-251. OUP: Buckingham.

NHS England (2026) Guidance on NHS registration requirements for use of psychological professions titles. London: NHS England. https://www.england.nhs.uk/publication/guidance-on-nhs-registration-requirements-for-use-of-psychological-professions-titles/

NICE (National Institute for Health and Care Excellence) (2018) Post-traumatic stress disorder. NICE guideline NG116. London: NICE.

Palmer, S. and Woolfe, R. (Eds.) (1999) Integrative and eclectic counselling and psychotherapy. Sage: London.

Parloff, M.B. (1961) Therapist-Patient Relationships and Outcome of Psychotherapy. J. of Consulting Psychology. 25 29-38.

Pavlov, I.P. (1927) Conditioned Reflexes. OUP: London.

Pilgrim, D. (1990) British Psychotherapy in Context. In Dryden, W. (Ed.) Individual Therapy – A Handbook. pp. 1-17. OUP: Buckingham.

Richards, B. (1983) Clinical Psychology, the Individual and the Welfare State. PhD thesis, North East London Polytechnic.

Rogers, C.R. (1951) Client-Centred Therapy. Constable and Company: London.

Rogers, C.R. (1957) The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology. 21, pp. 95-103.

Rogers, C.R. (1962) The Interpersonal Relationship: The core of guidance. Harvard Educational Rev. 32, 416-429.

Rogers, C.R. (1963) The Concept of the Fully Functioning Person. Psychotherapy: Theory, Research and Practice. 1(1) pp. 17-26.

Rogers, C.R. (1966) Client Centred Therapy. In S. Arieti (Ed.) American Handbook of Psychiatry. 3, pp. 183-200.

Rogers, C.R. (1975) Empathic: An unappreciated way of being. The Counseling Psychologist. 5(2), pp. 2-10.

Rogers, C.R. (1980) A Way of Being. Houghton Mifflin Co.

Rogers, C.R. (1990) Carl Rogers Dialogues. Constable: London.

Rosenzweig, S. (1936) Some implicit common factors in diverse methods of psychotherapy. American Journal of Orthopsychiatry. 6, pp. 412-415.

Rush, A.J., Beck, A.T., Kovacs, M. and Hollon, S. (1977) Comparative efficacy of cognitive therapy and imipramine in the treatment of depressive outpatients. Cognitive Therapy and Research. 1, pp. 17-37.

Saunders, S. (1999) It has been amply demonstrated that psychotherapy is effective. In Feltham, C. (Ed.) Controversies in Psychotherapy and Counselling. Sage: London.

Schön, D.A. (1983) The Reflective Practitioner. Ashgate: London.

SCoPEd Partnership (2022) The SCoPEd Framework: Scope of Practice and Education for the Counselling and Psychotherapy Professions (amended 2025). https://www.bacp.co.uk/about-us/advancing-the-profession/scoped/

Seeman, J. (1954) Counselor Judgements of Therapeutic Process and Outcome in Rogers, C.R. and Dymond, R.F. (Eds.) Psychotherapy and Personality Change. pp. 99-108.

Skinner, B.F. (1971) Beyond Freedom and Dignity. Middlesex: Penguin.

Smith, D.L. (1990) Psychodynamic Psychotherapy: the Freudian Approach. In Dryden, W. (Ed.) Individual Therapy – A Handbook. pp. 18-38. OUP: Buckingham.

Stone, M. (1985) Shellshock and the psychologists. In W.F. Bynum, R. Porter and M. Shepherd (Eds.) The Anatomy of Madness, Vol. II, London: Tavistock.

Stone, M.H. (1977) Dreams, free association, and the non-dominant hemisphere: An integration of psychoanalytic, neurophysiological, and historical data. J. Am. Acad. Psychoan., 5, pp. 255-284.

Stone, M.H. (1998) Healing the Mind – A History of Psychiatry from Antiquity to the Present. Pimlico.

Teasdale, J.D., Fennell, M.J.V., Hibbert, G.A. and Amies, P.L. (1984) Cognitive therapy for major depressive disorder in primary care. British Journal of Psychiatry. 144, pp. 400-6.

Thorne, B. (1990) Person-centred Therapy. In Dryden, W. (Ed.) Individual Therapy – A Handbook. pp. 104-126. OUP.

Thorne, B. (1992) Carl Rogers. Sage: London.

Wampold, B.E. and Imel, Z.E. (2015) The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work. Second Edition. Routledge: New York.

Wampold, B.E., Mondin, G.W., Moody, M., et al. (1997) A meta-analysis of outcome studies comparing bona fide psychotherapies: empirically, ‘all must have prizes’. Psychol. Bull. Nov, 122: 203-15.

Watson, J.B. and Rayner, R. (1920) Conditioned emotional reactions. J. of Experimental Psychology. 3, pp. 1-14.

Wollheim, R. (1973) Freud. Fontana: London.

Wolpe, J. (1958) Psychotherapy by Reciprocal Inhibition. Stanford University Press.

Wolpe, J. (1976) Behaviour Therapy and its Malcontents. J. of Behaviour Therapy and Experimental Psychiatry. 7, pp. 109-116.