CHAPTER 1

# EXPERIENCES OF MISUNDERSTANDINGS, CONFLICTS, PREJUDICES AND DISRESPECT ABOUT AND BETWEEN THE TWO APPROACHES

This chapter comprises a dialogue between the authors, clearly describing the conflict we have experienced between the two approaches which we represent and the ways in which we have experienced misunderstanding, even prejudice and disrespect, towards those approaches. This will include some reflection on our perception of the political landscape in the world of therapy, leading to a challenge to the reader to suspend disbelief and be mindful of the question, 'Whose purpose is being served by the conflicts?'

The chapter will also consider our opposition to the concept of 'doing a bit' of either person-centred or cognitive behavioural approaches and our commitment to the need for therapists to feel secure in their own chosen modality. This will include some exploration of what appear to be misunderstandings of both approaches, demonstrated through examples of therapists who either stick too rigidly to the purist principles of their original training or (mis)understandings of that, as well as therapists who draw on methods from other approaches without the required theoretical rigour or coherence.

For the purposes of this book, we use the collective terms 'PCA' and 'CBTs' to reference the core generic models and, where necessary, will make explicit any reference to one or another of the specific sub-types when a particular element is not apparently central to the model.

## So, where do we begin, why are we writing this book?

We set out to write this book because the perceived conflict between our modalities has long been acknowledged but never openly addressed and explored. Instead of expressing this in attitudes of disrespect towards each other's modalities, we wished to open up the issues to challenge and dispute the prejudices and assumptions that have built up around both CBT and PCA. This book aims to dispel ignorance about the fundamental differences and similarities in the therapeutic approaches in an open, balanced and non-defensive way.

We both recognise and accept that in the past we have been guilty of having what amounts to missionary zeal to convert others to believe that our particular approach is actually the 'Holy Grail' and no other approach is worthy.

Jeremy recalls that when Roger first invited him to come and do some teaching on the Diploma in Person-centred Counselling at Warwick, his reaction was to immediately think of 'spreading the light about CBT' and converting the students to his beliefs and practice! Jeremy quickly discovered the need to dispute his own irrationality when he discovered how undefended and non-defensive the person-centred tutors and students were in response to his challenges about their approach.

We wondered if we might begin by surfacing some of the range of stereotypes that we have experienced being attached to us and to our approaches.

### Stereotypes of the person-centred approach

- Woolly
- Nice
- Soft and fluffy
- Superficial
- Easy
- Theory thin
- Excessively warm
- Completely non-directive
- Amateurish
- A religion
- Not challenging
- No scientific basis
- Just listen, nod and say, 'Uh, huh'
- Mirroring and simple repetition
- Just repeating what the client says
- Useful for middle-class neurotics with no real problems
- Can't work with abuse victims
- No good for clients with mental health problems
- No good for short-term therapy
- Tea and sympathy
- It's all about the core conditions

### Person-centred counsellors are usually either:

- Men with beards and Jesus Boots who nod a lot
- Women with flowing skirts and lots of hair and beads and candles who hug a lot
- Soft and fluffy
- Determined to be nice
- Not very intellectual

### Stereotypes in the cognitive behavioural approach

- Cold
- Not interested in feelings
- Abusive
- Very directive aggressive
- Very medical
- Disrespectful to clients
- Aloof
- Not interested in the client's story
- Only working to the counsellor's agenda
- Homework is the only technique that is used
- It's all about the ABC model
- Technique, technique, technique and no process
- The therapeutic relationship doesn't matter
- Reductionist
- All about solutions and quick fix
- Simplistic
- Couldn't work with abuse victims
- No good for mental health problems
- Can't work with people with learning difficulties

### Cognitive behavioural therapists usually are either:

- Always male, with PhDs in psychology
- Young
- Snappily dressed and carrying clip boards
- Very intellectual

One thing we both know about stereotypes is that they always contain some truth and they are not THE truth. It is the truths that these stereotypes carry that we want to dispute in this book because we hold the view that these stereotypes are at the root of a really unhelpful and unprofessional set of prejudices by one school of therapists towards another. We are choosing to do this in particular in relation to the two approaches which we represent. We hope that, as a result, colleagues from other approaches will begin to reflect on what they might need to choose to do in order to be properly respectful of colleagues from other modalities. We would like to challenge the reader to be aware of their own prejudices, even to write them down, with an aspiration to recognise them for what they really are and dispense with them. We want to encourage you to take in their place a position of evenly suspended judgement, towards the philosophical, theoretical and practice belief systems, held by other colleagues from different modalities.

By working together over a number of years and developing a much deeper understanding of the theory, philosophy and practice of others' approaches, we

have been able to develop a significant respect for each other as practitioners and for each other's belief systems. This respect holds within it a deeply held willingness to agree to differ and to be accepting of different points of view as a paradox to be held, rather than as a polemic which must forever be argued. This respect transcends mere liking and sycophancy and has enabled us to discover the important similarities and parallels in what we do as therapists and the reasons why we do them. This has been alongside the process of getting a real understanding of the different beliefs we have and the different ways of practising and the theoretical reasons for these. For both of us, this has not resulted in a change in our practice or in either of us becoming 'integrative'. It has, though, brought a richness of understanding of how our approaches work for us. For Roger as an 'Orthodox' client-centred therapist and for Jeremy as a very rational Rational-Emotive Behavioural therapist, we have both become more clearly attuned and committed to our respective core modalities while at the same time developing a very challenging accepting of the other's modality. Through the process of our developmental journey, we have learned to stop anthropomorphising our respective models by recourse to recalling personal attributes and idiosyncrasies of bad examples of practitioners from the other's modality. We would like to invite and encourage the reader to take a stroll along a similar path in this book.

We are both firm proponents of the need for therapists to have a core modality and are rather suspicious of the concept of 'integrative'. We both have difficulty in understanding how very different philosophies can be integrated when they are so diametrically opposed. In the same manner, we are both opposed to the notion of, in Roger's case, 'doing a bit of person-centred' or, in Jeremy's case, 'using a bit of CBT'. This is anathema to both of us!

With the development of the so-called Layard model of therapy, the CBTs have increasingly been perceived as being associated with a medicalised model. Much of this assumes that such a process of medicalisation enables the CBTs to achieve kudos *per se* (Tudor, 2010); that the predominance of the CBTs through the aegis of Improved Access to Psychological Therapies (IAPT) has led to the marginalising of other approaches (Cooper & McLeod, 2010); and that the model is simplistic and reduces client choice (Tudor, 2008).

It is evident that some of these criticisms relate to fundamental differences in language and philosophy, although it is also probable that this is indicative of a considerable degree of rhetorical semantics. It is also likely that the proliferation of the CBTs following the Layard model has done little to address these differences. The assumptions underpinning the Layard model have been explored by some authors (e.g. Tudor, 2010), particularly the political and philosophical 'utilitarian flavour' and 'the UK government's obsession with promoting brief (time-limited) cognitive-behaviour therapy (CBT) to the greatest number for what it thinks is the greatest good' (Tudor, 2008: 118–136).

The political landscape in the world of therapy is such that therapists of whatever persuasion cannot escape or ignore the developments which are taking

place at a national level. It is very clear that the government and the army of civil servants and health service managers are not the least bit interested in the differences between the therapeutic models. They are caustically critical of what they see as tribal bickering inside the profession and have no patience with it. In a very real sense, this plays right into the hands of those who are totally focused on reducing expenditure and resources for psychological approaches to mental health.

We would like to offer now two examples from our experience of therapists 'trashing' the other modality.

### *Example 1*

The first example is about a proposal from a young psychiatrist to a Team Leader of a small team of therapists working in a National Health Service setting. All the counsellors in the team had qualified with a University Certificate and Diploma in Person-centred Counselling and Psychotherapy. They had all been practising for several years and had continued to undertake regular continuing professional development courses to enhance their practice. The psychiatrist recommended that the counsellors in the team should only be working with clients who had been given a diagnosis, either by himself or by a GP, of a mental health condition. The psychiatrist and the Team Leader then jointly proposed that all the counsellors in the team should undertake a full course of training in CBT in order to be competent to work with clients with mental health issues.

When challenged by the team, they were told that they needed to do the training because it was politically expedient to do so. They were then told that they could do the training, but that when they closed the door of the counselling room, they could choose to continue to work as they had always done! In addition to suggesting they should do something which seems highly unethical, this also implies a high degree of professional disrespect towards the counsellors concerned and a substantial level of ignorance about the approach they have been trained in.

### *Example 2*

The second example involves an experienced counsellor who was working within a multi-professional team dealing with clients who posed a risk owing to dangerous behaviours. At a team discussion regarding a client, the counsellor presented her conclusions and a tentative formulation and included a description that the client had disclosed severe childhood abuse and that this was to be the focus for their work during the coming sessions.

Members of the team expressed concern that, given the nature of the risk associated with the client combined with their history of sexual offending, it was both appropriate and necessary for the team to share information about their contact with the client, and particularly when very difficult and sensitive information was being considered. However, as she had external supervision arrangements, the counsellor believed that these issues would be discussed and dealt with in that context alone.

The counsellor reacted very strongly to the team's concern to share information, stipulating that she considered that it would be 'unethical' for her to disclose the content of sessions as this would 'breach confidentiality' and could undermine the

therapeutic relationship between her and the client. Despite the arguments posed by the team, the counsellor stated that, as the professional in the team who had the therapeutic relationship, she was best placed to understand and empathise with the client. Furthermore, it would be through her acceptance of the client that change could occur; other members in the team would not be placed to understand the process or how this might relate to the client and their behaviour. In addition, according to the client, the incidents that resulted in the convictions had occurred historically and he had not been in a position to defend himself, whereas now it would have been unlikely to have resulted in a conviction.

The counsellor simply refused to discuss the matter and indicated that, in the event that she considered that there was a risk posed by the client, she would detail a general concern to the team but would not provide specific detail. In response to a member of the team whose orientation was cognitive-behavioural, the counsellor suggested that this was a 'simplified model that ignored the emotional impact of these events in his life' and that therefore this colleague would inevitably have a 'simplified view of the client'.

The counsellor was obviously acting in an unethical manner and chose a very rigid interpretation of the nature of confidentiality, and her use of the supervision relationship reflected her generally defensive reaction. Given the risks involved in the case, it was both necessary and appropriate to share critical information with colleagues and also to have respect for their own professional boundaries. Similarly, the rather offensive dismissal of a CBT colleague as being 'simplistic' and ignoring the emotional context appears to have served purely to bolster her justification and defensive position. It appears evident that this overlooks the very central issue of different 'truths', all of which have value.

These examples suggest a significant issue for both approaches, in relating to practitioners in each approach being prepared to fully value the other approach. This parallels a shared fundamental philosophical position that human beings are intrinsically of value and that no one human being is more valuable than another. It is tempting and easy to suggest that in the two examples above these are inappropriate practitioners. However, their attitudes may also be evidence of an un-reflected attitude in both approaches, that their approach is of more value than the other. And yet, above, we have identified at a philosophical belief level that both approaches believe the same thing about human beings.

## A link to the next chapter

In the next chapter we intend to briefly compare the main philosophical tenets which are the basis of each of the approaches, clarifying the similarities and the differences. This will include sections on: humanism, phenomenology and existentialism as philosophical principles. It will also make reference to elements of theory and practice in both approaches and how these are rooted in and are expressions of philosophical principles.

## Recommended reading

Casemore, R. (2011) *Person-centred Counselling in a Nutshell* (revised edn). London: Sage.
Neenan, M. & Dryden, W. (2011a) *Cognitive Therapy in a Nutshell* (revised edn). London: Sage.
Neenan, M. & Dryden, W. (2011b) *Rational Emotive Behaviour Therapy in a Nutshell* (revised edn). London: Sage.