Psychotherapy and Counselling in Practice

A Narrative Framework

Digby Tantam

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Although case histories are drawn from actual cases, every effort has been made to disguise the identities of the individuals involved.

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1

Establishing the concerns

Why start with the consideration of concerns?

Starting a book about psychotherapy with a discussion of concerns is appropriate because it is a concern about something that takes people to a therapist in the first place. People seeking psychotherapy may be concerned about the symptoms of a psychological disorder. More usually, even if they have a psychological disorder, their concern is about a crisis in relationships or in everyday life – an existential crisis (Coursey, Keller & Farrell, 1995).

What is a concern?

Concerns are '. . . the more or less enduring disposition to prefer particular states of the world. A concern is what gives a particular event its emotional meaning' and emotions 'arise from the interaction of situational meanings and concerns' (Frijda, 1988). Concern is therefore 'a motivation construct. It refers to the dispositions that motivate a subject, that prompt him to go in search of a given satisfaction or to avoid given confrontations' (Frijda, 1986, p. 334).

An example of a concern

Alan suffered brain damage at birth. Despite this and the developmental problems consequent on it, he had been able to get to university, but found that he was unable to make friends or be taken seriously by his peers. His awareness of that diminished when he was with his family, with whom he had a close relationship, and, unless he thought or talked about the university, he had no particular distress about his social isolation when he was at home. When he returned to university, many incidents during the day reminded him of his social difficulties and made him angry and resentful. His resentment was associated with the feeling that other people should treat him better, and he often sat alone in the university bar watching other people together, and nursing his own distress.

Alan's resentment is a kind of concern. He was on the look-out for people who dismissed him because of his disability, and who did not respect his ideas or his personality. He believed that he was as good as the next person, but that other people did not recognize this. These beliefs were such that when Alan was put in mind of them, he would feel angry rejection or, if he was also lacking in self-confidence, miserable self-pity. Other people sympathetic to him would also feel anger or sadness on his behalf. However, less friendly people would feel more hostile and rejecting because they would find the flavour of Alan's concern unpalatable. He had a chip on his shoulder, they would say.

Concerns reflect what is important to a person and, as Frijda points out, may give rise to many different emotions. Frijda (1988) writes, 'One suffers when a cherished person is gravely ill; one feels joy at his or her fortune or recovery . . .' Disability is a very important issue for Alan, and is therefore one of his major concerns. Overwhelming concerns may lead a person to seek relief from a doctor, a priest, a counsellor or a psychotherapist.

Mrs Wright was on her way to London for one of the regular monthly meetings of the charity for which she worked. As usual on these trips, she had brought some work with her but, as usual, she was lost in not unpleasant reverie. The journey seemed no different from many others until the train braked so hard that she was nearly thrown from her seat, and an elderly lady across from her did actually fall to the floor. Mrs Wright felt her heart take a sudden bound, and her mouth went dry. It was some moments before the thought formed in her mind that: 'We are going to crash'. Almost immediately there was a bang followed by repeated sounds of metal tearing. Mrs Wright hardly noticed. She had been thrown forwards almost over the seat in front of her and shortly after thrown sideways as the carriage in which she was travelling twisted onto its side. She fell onto the window, which had shattered. She was lucky not to have been cut by the glass. A man that she had noticed before was not so lucky. He was thrown with great force from one side of the train to the other, and glass penetrated his face, causing copious bleeding. Mrs Wright felt overwhelmed with horror as his blood splattered her. She was shocked to find herself thinking not of this man's injuries, but of the possibility that he might be infected with HIV and that the virus might be transmitted to her.

This is an extreme example of an overwhelming concern about personal safety. Mrs Wright wanted relief from the flood of unpleasant emotion that the situation, and her concern about it, had released. One component of psychotherapy, and of medical or psychological practice, is to provide the sort of relief that Mrs Wright was seeking. Some of the techniques that can be used are discussed in Chapter 6.

Concerns and psychotherapy

Concerns orientate us in our environment. They enable us to prioritize occurrences and to ensure that happenings that activate our deepest concerns get, *ceteris paribus*, most of our attention (Oatley, Jenkins & Stein, 1998). This process most often occurs outside awareness. In fact, when the concern leads imperceptibly to an action that takes care of the concern, we may have no awareness of there being a concern at all. Others, such as psychotherapists, might be able to infer the concern from observing a pattern in our actions, however. If no immediate action suggests itself, we may become aware of the concern because we become aware of feelings and thoughts associated with it. We might experience ourselves concentrating on a problem, or finding ways round a difficulty. We might experience ourselves on the defensive, or using our winning ways. We might, in other words, have to self-consciously recruit learnt means of resolving the concern. Very often this will be successful. But sometimes, it will not. It is these situations, of unassuaged concern, with which psychotherapists are concerned.

Concerns are normal. They engage us with the world. A lack of concern, perhaps associated with indifference, apathy or boredom, may also lead a person to consult a psychotherapist or, more often, to lead someone else to recommend psychotherapy. I do not think that psychotherapy is going to be practical for someone who has no concerns. But it may be enough for a person to feel concerned about their lack of concern. In fact, as we shall see in Chapter 10, concerns that are hidden are often the ones that most destroy happiness.

The three elements of a concern

Frijda's use of the word concern is subtle and ambiguous, befitting a term that is to be useful in psychotherapy where both subtlety and ambiguity are highly prized. Concern can be used as a feeling, as in, 'Jane's back late. I'm feeling quite concerned'. It can be used as an indication of thought, as in, 'Our first concern should be to find out whether she has already left the party'. Or, it can be applied as Frijda probably intended it, to values, as in, 'You're always so concerned when Jane's away. I think that you care more about her than you do about me'.

Of the very many ways in which human action can be classified, a three-fold classification has emerged as the most influential in psychotherapy. It has been argued that a preference of three-fold models reflects familiarity with three spatial dimensions. Harre has also suggested that models of the mind do not reflect reality, but create – and therefore restrict – it (Harre, 1979). We should, therefore, treat any model of the mind with some scepticism. However, this does not apply solely to the models used by psychotherapists, but also to our own commonsense psychology which blinkers us as much as any other model, if we let it.

Case example

Howard was admitted to an observation ward, having arrived at work, bought a cup of coffee as he always did, and then repeatedly gone up to people in the lobby saying, 'I don't know what to do next'. He had a bruise on his forehead, and was obviously confused. He had cycled to work, and it was assumed that he had either had an accident, leading to a head injury, or that it was a confusional state. Over the next 3 days, Howard's state improved. On the second day, he began ringing his colleagues, apologizing that he had missed appointments with them, but was unable to make alternative appointments as he had no sense of his future plans. He later said, 'It was as if my mind had gone silent'. Normally, there would be constant chatter of plans, thoughts, ideas, hopes, and so on. That had all disappeared. There was only the now. On the third day, he was no longer clinically confused and he was allowed to go home. His condition returned to normal over the next week, but there was a nagging problem about what had caused it.

Howard reasoned that even if he had no conscious memory of what had happened to him, he would have an autonomic memory. He therefore set out on his bicycle to undertake the same journey to work. This time, though, he stopped regularly to take his pulse. It increased at the beginning of the journey as he began to exercise, but then remained at the same rate until he approached a section where there were large trees. The rate went up progressively as he approached a particularly large oak, which had a limb over the path along which he was cycling. Stopping under this limb, Howard realized that if he was at full stretch he would have struck it with his forehead. Standing under it, straddling his bike, he felt uncomfortably anxious and he concluded that it was here that he had had his accident. He would probably have fallen off, and then remounted to continue his journey, but with a frontal lobe deficit. He could complete the journey and buy his coffee as he always did, because these plans were already 'laid in' and did not require conscious deliberation. When they had been completed though, and he had to think about what he had to do that day anew, his deficit had become apparent.

Howard was concerned, following his head injury, that there was some hidden danger in his environment. It was hidden from his thought by amnesia, but it was detectable using his emotions, and the different memory system subserving them (Ikeda et al., 1998). Since Howard had no conscious memory of what had caused the injury, his anxiety was the only manifestation of his concern that he should not be injured in a similar way in the future.

Had he not conducted his experiment, Howard would be in the same situation as any other animal which has been injured in a particular place. The animal learns, or as the jargon goes, is conditioned to experience fear in association with stimuli associated with that situation. This fear might extend to other stimuli of a 'similar' kind (see Chapter 5 for a consideration of what 'similar' means in this context).

Animals, including people, live in an environment which contains many conditioned stimuli. The anxiety that these stimuli evoke is the means by which the animal demonstrates its concern for its physical safety. The Howard case indicates that the concerns of people, too, may be furthered by emotions elicited by the environment without the mediation of thought although, as I shall argue in Chapter 5, the emotions may be complex and are by no means restricted to anxiety.

Howard was not content to rely on instinct to preserve him from further harm. He wanted to know what had caused it. Having conducted his experiment, he would not only have his feelings to alert him to possible danger, he would be able to use his conscious appraisal of his environment to look out for trees with overhanging branches. Howard, as it turns out, was not a devil-may-care person. Had he been, he might have taken a different attitude to danger than he did. Rather than avoiding tree-lined paths, he might have sought them out, to show his lack of fear, even to free himself from any such mundane concern as a fear of injury. It is likely, although there is no evidence to prove it, that this devil-may-care attitude would not have been present during Howard's convalescence. It would most likely have returned when he started again to be aware of plans, wishes and long-term goals, as he began to be, just before discharge. Howard's concern to preserve himself may have been subordinated to a more important concern for him to see himself, or to be seen, as 'macho'.

The reader will note that there is a ternary model implicit in this description of Howard. The three elements are emotions, attentive appraisal, and values. It is interesting to note that, in Howard's case, it appears that these elements are differentially affected by the head injury, recovering at different rates. It may therefore be, although further study of people recovering from head injury would be needed, that when a person is concerned about something, three distinct neural substrates are involved. What matters more for the purpose of this chapter is that when a person expresses a concern, or when we speak of a person's concerns, we are referring to 'emotions', 'attentive appraisal' 'and values'. These three terms are not meant to be exhaustive. There are many other independent aspects of mental function. Each of these aspects of concern also draws on previous experience and thinking. Emotional responses are affected by the emotional meanings, which are discussed in Chapter 3. Attentive appraisal takes place in relation to beliefs. For example, Howard's appraisal of the threat of the tree was determined by his belief that tree trunks are harder than heads. Values are also informed by beliefs, and particularly the strongest beliefs – convictions – which seem to be beyond question.

The ternary model of psycho-analysis

In many psychotherapeutic approaches, a particular mental agency, often called 'the unconscious', is held to be responsible for emotional responses and for impulsive actions following on from emotions. The concept of the unconscious was particularly developed by Freud (Freud, 1940), but he had a number of influential forerunners (Ellenberger, 1970). A great deal of twentieth century thought has been shaped by the awareness of man's animal nature, as Nietzsche termed 'the unconscious' (Nietzsche, 1977).

As is well known, Freud developed his ideas about the unconscious more as his thinking developed. He presumed that there were two unconscious agencies – the 'It', which was man's animal, 'primitive', nature, and the 'over I', which was a crystallization of social prohibitions, created by the child's experience of paternal repression. These two, the It and the over I, or, as Strachey renamed them, the id and the superego, battled it out for the ear of the third agency of the mind, the 'I' or ego. The ego is not quite the self, but comes closest to what philosophers call 'the agent'.

Freud, too, therefore had a ternary model of mental function. It was based on conflict rather than partnership, and it placed considerable emphasis on men and their struggle to master themselves.

Freud's immense success in popularizing the idea of the unconscious has meant that his contribution has over-shadowed not just psychotherapy, but popular culture. It is difficult to escape this grandparental influence. Freud was an extremely fertile and wide-ranging thinker who made new contributions in very many areas. Even defending and criticizing Freudian psychology has become a major literary industry. It is almost certain to turn out to be as pointless as arguing about Paracelsian medicine was in the seventeenth century. I do not intend to contribute to it.

Freud's preoccupations have been passed on to younger psychotherapists, and continue to influence, sometimes adversely, the development of the profession. Freud was preoccupied by seductive women and repressive men, by childhood, by sexuality, by mental struggle, by the psycho-analyst's power to know what others did not, by the rightness of civilization, and by the dangers of man's 'animal nature' (Midgeley, 1979).

A psychotherapist in training today cannot remain neutral to Freud. His name, like the concept of the unconscious, has become a sort of rallying call. Joining another camp is not an answer: cognitive-behavioural psychotherapists, existential psychotherapists and interpersonal psychotherapists all have their characteristic concerns too.

What I try to do in this book is to set aside these concerns as much as I can without necessarily setting aside the ideas with which they have been linked.

What is a concern?

I have already noted that a concern has three elements: emotion, appraisal and value.

Richard was a young man with autism, preoccupied by the world news. He was convinced that some disaster was at hand, and would often wake his mother in the night to ask her for reassurance. She had a recurrence of a breast cancer, and was already very stressed. She could not deal with her son's difficulties, which she attributed to his autism. He was referred to a psychotherapist, who quickly discovered that his mother had never told him about her state of health, although he had guessed it. She did then tell him, on the advice of the psychotherapist, and the psychotherapist suggested to the young man that his concern about his mother may be at least as important as his concern about the whole world. His behaviour improved. Some months later, his mother died and, within the next 12 months, so did the young man's father and grandfather. He was completely unprepared, became depressed, and began to drink heavily.

The three components of Richard's concern are obvious. He valued security above all things, and was therefore preoccupied by the possibility of disaster. His world was suffused with anxiety about death, which gave particular emphasis to the threat of war. And he was trying to work out what he could do to avert the catastrophe that he felt was looming.

Richard's concern was 'real'. His history dates from a time of cold-war tension when many people were starting to commission nuclear bunkers in their back gardens. But this was not the concern which was really bothering him. The really bothersome concern was no more nor less real, but it was a bigger concern or, as Stock Whitaker puts it, a more preoccupying concern (Whitaker, 1985).

The therapist was aware of the three components of Richard's concern, but made the mistake of thinking that Richard's real concern was that his mother might be concealing a relapse of her illness. But, as events showed, Richard had legitimate concerns about independent living which were, arguably, the real concerns that he was experiencing all along.

How does the discussion of concerns differ between medical or psychiatric practice, and the practice of psychotherapy?

Very little one might say, if ordinary everyday medical practice is considered, since people going to doctors are just as concerned about the emotional and spiritual significance of their problems as people going to psychotherapists. But the goal of the physician or psychiatrist is different. She or he must behave as a positivist, and find out whether the concern is real in the sense of being material.

Doing this involves many activities which are similar to those of the psychotherapist in an assessment. There has to be a recognition that clients may withhold information to protect themselves, others or the doctor. They may misinterpret experiences, and they may be unaware of important information which has to be elicited directly or even inferred.

Assessment

Activities are often collectively called 'clarification', and I will use that term too. However, it is important to note that clarification is not merely a process of exposing what is there. The person doing the clarifying is concerned, too, to achieve a particular end, and this influences what becomes clear.

A few years ago, it was a common practice for trainee psychiatrists to include, in their mental state descriptions, expressions like: 'Depression. Present subjectively, absent objectively'. What this purported to mean was that the person who complained of depression did not look depressed. But such statements were often the consequence of a hard-pressed junior psychiatrist meeting an unhappy person threatening to take an overdose in casualty in the middle of the night. The junior psychiatrist is concerned not to 'block a bed' or to be made to look a fool in the morning when the client is discovered to be a regular user of mental health services and, as the consultant may disparagingly term him, a 'known personality disorder'. But the psychiatrist is also concerned not to appear in the coroner's court and have to explain why a person who says that they are going to kill themselves was not taken seriously. So the psychiatrist starts out his or her clarification of the client's symptoms with the intention of making clear whether or not the client is 'objectively depressed'.

The medical paradigm is that clarification of the concern leads to a pattern which the doctor can recognize as being caused by an abnormality of bodily functioning. In ordinary practice in many medical specialities, and especially in psychiatry, this paradigm is an ideal. The normal process is that the doctor recognizes a pattern which can be changed by some intervention, and the bodily malfunction is either inferred or unknown. However, either way, clarification leads to an intervention which deals with whatever is causing the things which are concerning the client. And this is backed up by the supposition that, sooner or later, the bodily malfunction will be discovered.

Many psychotherapists consider that this paradigm can be made serviceable for psychotherapy by widening the range of possible causes to include memories and learnt responses. Traumas, maladaptive learning, insecure attachment and negative automatic thoughts have all been proposed as causes of psychological disorder. This adoption of a causal model of psychotherapy has many advantages. It enables easier dialogue with other mental health professionals. It is a tried and tested paradigm, which lends itself to research. It avoids blaming clients with mental disorder.

However, it has two disadvantages. Being considered to be mentally ill is, according to the causal model, to be considered to have emotional difficulties caused by external factors. Most people believe that they are responsible for the character or abilities that protect them from reacting badly to adversity (Rogers & Pilgrim, 1997), even if they do not consider that they are responsible for their immune system's capacity to fight infection. For many people, becoming mentally ill is therefore to have given up responsibility. The more the doctor tells someone that they cannot help themselves because their illness is, like pneumonia, caused by something that is out of their control, the more problematic it is for the client. If the client values self-control highly, he or she may pretend to agree with the doctor, but think that the doctor does not really understand mental problems. If the client goes along with the doctor, it may be difficult for him or her to know what they are responsible for. Perhaps getting angry that the lunch is late is also caused?

A second disadvantage is professional. In the ordinary world of medicine, a client who coughs up blood may be successively visited by an infectious diseases specialist, a chest physician and a surgeon. Each may clarify the problem in such a way as to make it out to be particularly susceptible to their style of intervention. The infectious diseases doctor may get a history of night sweats and a lack of BCG immunization, and the surgeon might emphasize the long history of smoking and the irregularity of the enlarged regional lymph nodes. However, their disagreement can normally be resolved by further physical findings. There is a constraint set on their rivalry by this appeal to a shared material world. If the proponents of tuberculosis as a cause of haemoptysis begin to outnumber the proponents of carcinoma, it is likely to be because they predict these physical manifestations more accurately and not because they are better politicians.

When a cognitive-behavioural therapist uncovers negative automatic thoughts and a psycho-analytic psychotherapist uncovers transference problems, both seeing the same client, how can their different points of view be resolved? The evidence seems strong that different psychotherapy modalities are more similar in their effects than they are different (Stiles, Shapiro & Elliott, 1986). Even if this were not so, it is clear that there is a substantial non-specific effect in psychotherapy (Frank, 1984) and that almost any intervention can be effective some of the time and in some people. There can therefore be no definitive test of outcome which shows one account to be true, and another not.

Causes and reasons

Another way of contrasting medical and psychotherapeutic practice is to say that the former is about finding a cause for the client's concern, and the latter is about finding a reason for the concern. Clarifying the cause for concern leads to a diagnosis which, it is assumed, would be reached by any competent practitioner discussing that concern. Clarifying the reason for a person's concern leads to a consensus between the client and the psychotherapist about why the concern has arisen, and it is recognized that a different consensus might be reached by another practitioner. This is not just because there are many reasons for a person acting as they do, for there are also many causes. It is because the concern may exist long before the reason for it has been formulated (Tantam, 1999b). This is not to say that reasons are merely epiphenomena of causal chains. Once brought into being, they are causally effective.

A woman notices that her husband is abstracted. 'You're hallucinating again', she says to her husband, 'because you didn't take your tablets.'
A . . . 'You forgot to take your tablets.'
B . . . 'You don't like those tablets.'

The cause of the husband's hallucinations is the fall in his medication levels. His wife thinks that there is a reason for this, but neither of the reasons could have been causally effective. There was no act which corresponded to forgetting, nor to not liking, and so no act on the husband's part corresponding to either reason could have caused him not to take the tablets. But both of the reasons given by the wife are likely to have future causal consequences. She may institute a medicine diary if she considers her husband to be forgetful. Or she might get angry with him and try to change his motivation to take the tablets by indicating that his dislike of them will certainly be outweighed in the future by her dislike of him hallucinating.

Medical psychotherapists may need to consider the causes of their client's concerns, but are principally concerned with the reasons for them. The evidential criteria that they bring to bear on reasons are very different to those that apply to causes (Tantam, 1999b). That means that the process of clarification of the concerns is different too.

It is different partly because, like psycho-analysis, it is interminable. Since reasons for an action or an event may be brought into being after the action or event, fresh reasons can always be advanced. Indeed, in writing up many of the illustrations in this book, I have seen possible new reasons for the actions of the people that I describe.

Being a bit more practical about concerns

It would be a much simpler world if everyone knew what they were concerned about, and were able to express their concerns clearly and in a way that readily led to resolution. In fact, in this simple world, psychotherapists and counsellors would probably not be needed. For it is to psychotherapists and counsellors that people turn when they do not know the causes of their mental dis-ease. As the client said to the doctor, 'What's my problem? If I knew that, I would not need to come to see you'.

Lotty B. wakes in the small hours, wet with sweat and with her heart pounding. She is due to be admitted to see a surgeon in the morning for assessment of a lump in her breast.

(1) She has been dreaming of being at the dentist, but something had gone wrong and it was not as it should have been. More horrific. She feels somewhat calmer when she wakes because she hears her husband calmly breathing next to her. She snuggles up to him, and he mutters in his sleep. She thinks of how good he is, and drops off to sleep again.

(2) She has been dreaming of being at the dentist, but he is pulling out her nipple, not her teeth. As she wakes, she remembers the lump, and she is sure it is cancer. Her husband feels her rapid breathing and restlessness and wakes. They talk about the possibility. What he would do, and what she would do, if she does have cancer. She feels less alone with her fears, and realizes that even if it is cancerous, life will not stop immediately. There will still be much to live for. Her heart slows down, and her anxiety returns to manageable levels.

(3) She wakes out of a dreamless sleep, straight into the feeling that she is dying. She can't breathe. She struggles upright, and manages to slow her breathing down but there is nothing she can do about her heart. She knows that she will not get back to sleep that night. 'Surely there must be something very wrong with me', she says to herself. 'It must be cancer.'

Lotty B.'s anxiety dream in 1. is obvious and, as we would say, understandable. Her anxiety is resolved by a direct influence over her feelings through the relationship with her husband. She identifies with him, and with his quiet breathing, and that quietens her. Then she re-experiences the closeness of their relationship – as attachment theorists would say, how securely they are attached – and that further calms her.

In 2., Lotty remembers the dream. It has a propositional content, distorted but recognizable in the dream, accessible to her on waking, and understood by her husband. The concern leads directly to reflection and planning. 'Even if it is cancer, life does not stop.' The concern that presents intrusively and overwhelmingly is that there can be no future after the diagnosis, but her husband allays this concern when he indicates that he will continue to feel for her even if she does have cancer: '. . . life does not stop'. It seems to be this concern – that life will change after the diagnosis – that is the reason for Lotty's anxiety, and not her concern that she may die of cancer at some time in the future. Once it is allayed, she feels calmer.

Lotty B's panic in 3. is without propositional content. A sleep EEG would have shown that she awoke not from REM sleep, but from stage 4 sleep. This is often interpreted to mean that this type of panic attack is physiologically triggered and is without propositional content. The fact that Lotty is unable, even after waking, to put any meaning to her feelings, and that she concludes herself that the panic is merely the effect of a bodily disturbance, seems to bear this out. Panic attacks like this recur night after night, and are one of the commoner reasons for a mental health consultation.

What do these illustrations show about reasons and concerns?

We surmise that Lotty has some different concerns in each of these situations, and one concern that is the same. The different concerns relate to the quality of her relationship with her husband, and the kind of contact that she wants from him.

The concern which is common to all the situations is the emotional meaning. All of the dreams involve anxiety. In the first dream this meaning is not linked to the operation, but to the dentist, and it is merged into the emotional meaning of her husband sleeping beside her, suggesting that her concern is about separation.

The concern is much more explicit in the second situation. It is briefly about the dentist, but shifts quickly to the surgeon. This new concern seems much more overwhelming, because it is so much more threatening. Indeed, it is so threatening that the dream seems to be a sort of escape from the real danger, whilst preserving some of the feared elements, for example the interference with her breast. However, locating the anxiety in the forthcoming surgical appointment, and away from a story about the dentist, moves it on further. Lotty realizes that she is most concerned not, as a therapist might expect, that she will die or that she will suffer, but that she will become alienated from her husband. This is a concern which translates directly into a social action: a request to her husband which he convincingly answers – he will not abandon her, their life will go on.

In the third situation, there is no mention of a husband and Lotty's concern remains tacit. However, it seems possible that her anxiety attack is not merely coincidental with the appointment on the following day, but is linked to it, and that she does have the same concern as her avatars.

Preoccupying concerns

In her excellent book on group psychotherapy (Whitaker, 1985), Dorothy Stock Whitaker introduces the notion of a preoccupying concern. These are concerns which are fundamental to many other concerns, and which have a strong emotional flavour. This type of concern may colour an individual's reactions to many situations, and may occasionally manifest itself in a strong emotional reaction. Preoccupying concerns, like Lotty's, may be overwhelming, and yet not seem resolvable. They may intrude on a person's everyday actions, and create an emotional backwash that engulfs everything else. It is this kind of concern that usually takes a person to a friend or a healer. And it is this concern which the successful friend or healer locates and addresses.

Short-term dynamic, analytic or existential therapy is based on the assumption that it is a preoccupying concern or concerns which bring a person to the therapist. Clarifying the concern, or sometimes clarifying a sequence of linked concerns, is the main therapeutic activity of all these approaches, and is discussed in Chapter 9.

Another example of a preoccupying concern

Edward was coming to the end of his Master's degree. He had made a number of friends at university, and had enough money to enjoy himself. But he was dissatisfied. His life had not been as straightforward as he had hoped. He asked to see a psychotherapist because he had decided that he suffered from 'dysthymia', and wanted to discuss treatment options. The therapist reviewed Edward's history of broken relationships and of projects enthusiastically embarked upon, only to be dropped, his early separations from his parents, and his tendency to become anxious especially on leaving people he loved, and his depression when he felt rejected. The therapist suggested that Edward might have a deeper concern – to find someone or something on which he could rely and which would give him security and care.

Edward partly accepted this way of looking at his problem, but remained convinced that he did meet DSM-IV criteria for dysthymia and that he should receive drug treatment. He also pointed out that he was not so concerned about being close to people. He was, after all, a pretty successful guy.

The therapist was concerned not to reinforce Edward's view of the matter, and arranged a further meeting to discuss psycho-dynamic therapy. Edward did not attend.

Edward's concern was not the salient concern that brought him to see the psychotherapist. It was his concern that he had attention deficit disorder. The Lotty of the third situation – the one who just had an anxiety attack – would probably have expressed her salient concern as gaining relief.

Clients who come to see psychotherapists are not always as concerned as the dynamically orientated psychotherapist to understand why they feel as they do. They may want relief (see also Chapter 6), to be happy again (see Chapter 10) or, rarely, to understand why they keep getting into the predicaments that they do (see Chapter 9). They are, in other words, concerned about the kind of help that they will get.

Concerns about treatment

Many dynamically orientated psychotherapists believe, rightly in my opinion, that the emotional determinants of problems are considered far too rarely. They believe, therefore, that the clarification of a person's preoccupying concern, with its substantial emotional component, should be a more frequent response to problems. Organizational consultancy based on psychodynamic principles is successful, precisely because it provides explanations of the behaviour of people in organizations in terms of their emotional needs.

However, there are some circumstances when meeting an emotional need, or providing an emotional explanation, causes affront, not benefit. Consider the following:

Sugar-cane workers who were receiving benzodiazepines for treatment of palpitations and 'ataquos dos nervos' were found to have low blood sugars, due to overwork on a poor diet.

A disgruntled wife threatened to leave her husband because every time that she asked him why he was home late from work, and whether he had been seeing another woman, he told her that she was pathologically jealous.

The starvation faced by the sugar-cane cutters and the husband's concealment of his activities from his wife were ignored by others dealing with the problem. Maybe the others felt that they were helping, but it was practical help that was wanted and not emotional intervention. Denying this practical help increased the supplicant's sense of inadequacy and impotence. The importance of intervening only when a person is ready for it is stressed in motivational interviewing, a technique developed for the treatment of alcohol problems (Miller, 1983) but also applied more widely (Fowles, 1992).

One way to identify a person's concerns about treatment is to ask what they were hoping to get from the consultation (Lazare, Eisenthal & Wasserman, 1975).

Mr Hill had been diagnosed as having paranoid schizophrenia. He believed that he was the Saviour, and spent many hours, often until the early hours of the morning, reading the Gospels. Every so often he became more distressed and thought-disordered. Admission to hospital would be required, his medication would be increased and he would eventually settle down. It was thought that his wife was quite intolerant of his delusions, and that from time to time their relationship became acrimonious. On one occasion, he rang the doctor requesting an urgent appointment, and the doctor assumed that he wanted to be admitted to hospital because of rows with his wife.

Mr Hill was apparently more psychotic, but he seemed also to be expectant. The doctor asked him if there was anything that he hoped that the doctor would be able to do for him. With great hesitation, Mr Hill raised the question of Easter, which was just a few days away. Was it necessary, he asked, for someone who was the Saviour of the world to be crucified at Easter? Because, he said, he did not want to die. The doctor reassured him that the fact that one Saviour had died at Easter did not rule out the possibility of other sorts of Saviours, who

might never be crucified. Mr Hill seemed much reassured by this, and went home a calmer man. On subsequent meetings with the doctor, he said he thought that he might have been mistaken that he actually was Jesus Christ. Perhaps he was another sort of Saviour.

I do not think that Mr Hill would have brought up his concern unless he trusted the doctor to take it seriously, and not to ridicule him. Like many people with schizophrenia, he knew that no-one else would recognize that he was Jesus Christ, even though he was convinced that he was, himself. He could predict the humiliating rejoinder that doctors may sometimes make to clients who step out of the client role.

Fortunately, Mr Hill and the doctor had already established a mutually respectful therapeutic relationship. Had this been their first meeting, matters might have been different. The concerns that clients have about consulting a psychotherapist may determine the extent to which other concerns can be expressed.

Concerns about the therapeutic relationship

Going to see a psychotherapist is frightening. There may be enquiry into intimate matters, and perhaps judgement made or implied about one's personal behaviour. It is also disempowering. Psychotherapy remains an arcane undertaking, about which the therapist appears to know a lot, and the client little. The client's request for treatment may be rejected, if they are found 'unsuitable'.

The client may have high hopes, and delight in the opportunity of finally finding someone who will listen to their view of the world and their problems in it. But there will always be some negative expectations. They will be associated with a concern not be rejected, humiliated or shamed by the therapist.

Empirical research about shame indicates the dangers. In a diary study of women attending psychotherapists who had been sexually abused in childhood, Macdonald and Morley (2001) showed that some of the women decided during the course of their therapy to disclose the abuse to their partners for the first time. In a proportion of cases, the partner allowed the woman to express her feelings about the abuse, and accepted them. In these cases, the disclosure lessened the shame that the woman felt about the abuse. In other cases, the partner tried to get rid of the problem, rather than accept the reality of the woman's feelings. Very often, the partner's reaction was to get angry with the abuser, and sometimes to threaten to harm him or damage his reputation. In these cases, the woman very often felt more ashamed as a result of the disclosure.

An example of a concern about the trustworthiness of the therapist

Mr Slovoboda, a 40-year-old academic, came to his second selection interview in a hostile frame of mind. He was Czech, but brought up in Africa, most of the time by different uncles and aunts, or friends of the family. His parents had split up, and neither had wanted to raise him. He had been, as he said, searching for psychotherapy for 18 years. Since the first interview he had been ruminating on a remark that the assessor made, to the effect that not everyone benefits from therapy. He had concluded that this remark had been made to lay the groundwork for further treatment to be refused.

Mr Slovoboda was convinced even before he came to the first interview that he would be refused what he sought. This was, in fact, the most important theme of his life. He had been refused the care of his parents, and had concluded that others had kept them from him. He had begun a restless and intrinsically hopeless search for substitute care, but was always ready to identify those who would impede him and to fight to overcome them.

Mr Slovoboda's treatment never began. He had a series of mutually frustrating meetings with a psychotherapist who tried as hard as she could to be helpful to him. Mr Slovoboda was preoccupied with defending himself against her. He assumed that any help that would be offered to him would only be second-rate and that he should therefore refuse it.

The therapist's concerns

Psychotherapists are not without their concerns about therapy. The beginning therapist's preoccupying concern is likely to be 'not getting it wrong'. Mr Slovoboda's therapist who was working with a new consultant wanted particularly to show that she could be helpful. These concerns may sometimes be difficult to be put to one side, and may prevent the therapist from being fully aware of the client's concerns.

It is sometimes useful for beginning therapists to remember that psychotherapy shares many commonalities with other mental health practice. The skills that have been learnt there – or indeed in work as a teacher, parish priest or other professional concerned with the personal development of others – are the basis of psychotherapy skills. Even more importantly, the lessons about the limits of the professional's influence that are learnt in these other pastoral actitivies also apply to psychotherapy.

One of the greatest challenges for the beginning therapist is to determine the limits of their responsibility to their client. What if a client is suicidal? What if they report having committed a crime? More mundanely, but more commonly, what should the therapist answer if the client says, 'I came to you to get help with my problem and here it is, 4 weeks later, and I do not feel any better'?

The therapist needs to be clear about the limits of his or her own agency.

He or she is responsible – morally, professionally and sometimes legally – for what he or she does. But the therapist is not responsible for the client's actions. The therapist is not responsible, therefore, for taking away the client's concerns. This is an important difference from other types of practice.

Example of agency

Mr Y. goes to see his family doctor, complaining that he can't hear very well. Examination of the ear indicates that it is normal, but the doctor promises to arrange an audiogram. The client is relieved of having to do anything further, except wait. He may continue to worry, but he does not have to think what to do. If people ask him what is wrong with his hearing, he says that he does not know but is waiting for the results of tests, and this satisfies the enquirers. The doctor has become the agent dealing with Mr Y.'s hearing problem.

In fact the audiogram is normal, and the doctor tells Mr Y. that he need not be concerned about his hearing, because it is normal. Mr Y., who has come to the surgery confident that his hearing will be sorted out, finds all his old concerns returning, and protests that he still can't hear. He is so perturbed that the harassed doctor refers him to the practice psychologist.

She asks Mr Y. if he accepts that the tests are normal. He says that he does: he can hear sounds well enough, but he cannot hear what people say to him. She asks him if the problem is that he cannot take in what people say, and Mr Y. says, 'Yes. That's it exactly'. So far, the psychologist has not accepted responsibility for Mr Y.'s concern. She has only clarified what it is. It would now be possible for the psychologist to take responsibility for this new concern, and vie with the doctor in curing the problem. Mr Y. could be given some attentional exercises, for example, or the psychologist might investigate Mr Y.'s language processing.

Neither of these approaches would be wrong in principle, although both might be wrong for Mr Y. But neither would be psychotherapeutic. The psychotherapeutic approach is not for the psychologist to take responsibility for Mr Y.'s concerns, but to assist Mr Y. to find a way to follow these concerns to their conclusion. She might, for example, say to Mr Y: 'Do you have difficulty in taking in what everyone says, or is it just particular people?'. Mr Y. might say that he has particular difficulty in taking in what his daughter says. Further clarification might lead Mr Y. to the realization that he has his biggest problems when his daughter talks to him about her feelings about her upbringing.

What the psychologist has done is to help Mr Y. to clarify his concerns. She has not taken responsibility for them. Mr Y. remains responsible for what he hears, and does not hear. However, his concern has changed. He is now concerned that he can't hear what his daughter says about her feelings about her upbringing. And this new concern seems to be one that Mr Y. is more likely to be able to do something about than his previous blanket concern that his hearing was failing.

The psychotherapist's stance on agency and responsibility is not an easy option. It has to be balanced by a greater commitment to the autonomy of the client, and to the right of the client to confidentiality. Changing attitudes to the responsibility of mental health professionals to third parties have undermined their duty of confidentiality to their clients. Some agencies may require professionals to report to an investigative body a client's disclosure of actual or suspected abuse of a child. If a client tells a doctor of their intention to kill or injure another person, that doctor is ethically required to warn the potential victim or to take other steps to protect the third party. But even today, many psychotherapists take the view that, while they might do everything in their power to persuade their clients against a course of action that might harm others or themselves, they should be very reluctant to act independently to prevent it. This caution continues despite a ruling by the Californian supreme court in re Tarasoff that a psychologist has a duty to warn a possible victim.

As a house physician, I admitted a late middle-aged man who had just had a heart attack. His heart was failing and a chest X ray showed that there was substantial pulmonary oedema. There was no question about the diagnosis, or the possibility that he might die. He refused admission and insisted that he wanted to go home. He was slightly confused but understood that he had had a heart attack and that he might have another, or he might get more severe pulmonary oedema. He could give no good reason for wanting to go home other than that he would feel better there. My reality was that he was seriously ill and needed to be in hospital. My concern, in his place, would have been to do everything to save myself. His reality was also that he was seriously ill, but in those circumstances he believed that it was better to be at home (and I have to say that more recent research supports his position to some degree). His concern was to be psychologically safe, and that meant to be in a familiar environment.

I was so concerned that I asked a psychiatrist to see him who concluded that the client was not compulsorily detainable and no obstacle was put in the client's way of leaving hospital.

It is not possible to discuss deeply personal aspects of someone's life without it touching on concerns that one has oneself. In this instance, I was afraid that I would be seen by others to have done less than I should have for a client of mine. I have found over the years that I often need to consult colleagues in cases where I am afraid that I have not done enough. My instincts continue to be somewhat over-protective. I would, for example, warn a victim. But I recognize that there are times when this limits my ability to have a completely trusting relationship with those clients who want complete trust.

Sometimes these preoccupying concerns of the therapist stand in the way of dealing with the preoccupying concerns of the client. It is for this reason that many psychotherapists undertake a personal therapy as part of their training. This is not a complete solution to the problem of what may sometimes be termed counter-transference. The psychotherapists' concerns are not always due to their personalities or their past experiences, but may reflect their present circumstances, including their working practices. All psychotherapists need to be aware of their own concerns, and how these concerns might impinge on their work. Some clues about how one can monitor this, and what to do about it, are discussed in Chapter 11.

Identifying concerns

Some time ago, it used to be said that computers were changing our lives, and were taking over many of the tasks presently carried out by people, such as traffic control, record-keeping . . . and psychotherapy. This over-hasty conclusion followed on from work such as that of Marks and Carr (Carr, Ghosh & Marks, 1988), showing that phobias can be treated by a suitably programmed computer.

For clients who know that they have, say, agoraphobia, and are willing to consider this to be a learned behaviour which can be unlearned, computer-based treatment may be excellent. People are rarely so clear about their problem and its solution when they first see a psychotherapist, just as it is not usual for people to attend their doctors complaining of idiopathic hypertension, and asking for beta-blockers.

Doctors are used to having to clarify a person's concern. More transactionally minded doctors are aware that this may involve negotiation, as Balint (1957) noted, but there is reassurance in the knowledge that there is a 'real problem' to be found which can be demonstrated by tests or the response to treatment.

In psychotherapy, a person may have many concerns. Some of them will be causal ones, which can be addressed by appeal to an objective standard, such as the diagnostic criteria of depression. Others, and these are the ones that are of most interest to psychotherapists, cannot be. Enquiry into these concerns will often generate others, and enquiry into those will generate yet more . . .

Sometimes, as in the second Lotty illustration (see p. 19), the client themselves will indicate which is the preoccupying concern. But this may not always be the case.

Roger was a man with a history of angry, sometimes violent, confrontations with other men. He was referred for psychotherapy because of his increasing anxiety and depression. He spent the whole of the first session talking bitterly about having wasted his life. He related this to pursuing a career which was one that his father wanted for him, but which he did not want for himself. The next

session he talked only about his interest in his work, his wife's lack of understanding of it, and her lack of support for him. The therapist addressed both of Roger's concerns with understanding and empathy. He concluded that Roger had been emotionally deprived and hoped that he could make up for this in the therapy. As if to refute this, Roger rang to cancel the next session, saying that he did not think that anything could be gained by discussing his problems with the therapist, who did not seem to be able to understand his problems, which were just too deep.

The therapist wrote to Roger with a new appointment, and Roger came regularly for some weeks. After a while he started to describe his travel problem. He could never travel any distance from home unless he could be sure that he could contact either his wife or his father on his mobile phone. Very often he did ring them. When his father was away, he would have great difficulty in getting to work.

Camilla had an anxiety disorder. Over the 3 months during which she intermittently attended a general psychiatry out-client clinic, she spoke about her mother's abandonment of her, the threatening behaviour of one of her children, and her very poor home circumstances. This led to a home visit by the psychiatrist, after which Camilla failed to keep her out-client appointments and was counted as having dropped out of treatment. She was re-referred 6 months later, still with anxiety. After the first assessment, she had to be admitted to hospital with a head injury, and whilst on the ward, she developed some alcohol withdrawal symptoms. A great light dawned for the psychiatrist who asked Camilla at their next meeting why she had always denied heavy drinking. She said that it was always her intention to admit to it. Indeed, she knew that it was the reason that she was so anxious. But she just hated to think of herself as an alcoholic.

Both Camilla and Roger entered spiritedly into talk about concerns – in Roger's case about his emotional deprivation and in Camilla's about her anxiety. However, despite the apparent liveliness of these discussions, these were concerns that the therapist had formulated. They were not the preoccupations of the clients. Roger was preoccupied by his dependency on his father to be safe from anxiety, and Camilla about her alcoholism. However, they were both ashamed of these problems and so were also concerned to conceal them.

Useful therapy only began when the therapist found a way to focus on these preoccupations. These were the things that 'really' mattered to them.

But what does it mean to say that they 'really' mattered? There is no objective reality involved. How can the therapist recognize that a concern is the preoccupying one, the one that really matters?

When doctors think of reality, they often think of illness or death. Such things are givens that we all have to accept, irrespective of culture, religious belief or intelligence. Because of their regular contact with these realities it is