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*Chapter Thirteen*

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RESEARCHING PSYCHOTHERAPY IN BRITAIN:  
*THE LIMITS OF A PSYCHOLOGICAL APPROACH*  
[pp. 183-195]

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In this chapter, I will try to explore some of the difficulties entailed in British psychologists researching psychotherapy. At first sight, such limitations should be few in number given the defensible assumptions that psychotherapy is a psychological process and that the latter is scrutinised optimally, therefore, by researchers trained in academic psychology. However, these are dubious assumptions for three reasons. First, although psychotherapy is an interpersonal process, its own roots of phenomenology and hermeneutics have enjoyed only limited legitimacy within British psychology. For this reason, the research psychologist may approach the topic of psychotherapy with a sense of uncertainty if their core training has eschewed such areas of knowledge.

Second, the certainties surrounding quantitative methodologies underpinned by positivism and empiricism may take the psychotherapy researcher so far, in terms of studying therapeutic outcome, and the relationship between process and outcome, but at some stage a living sense of therapy-in-action can only be illuminated by alternative research strategies. Once more the research psychologist may be wary to take up such a challenge if their core training has provided them with neither the knowledge nor the confidence in such alternatives. My third doubt about psychologists being well placed to study psychotherapy relates to the issue of psychology *ipso facto* being *psychological* when psychotherapy is a form of practice which is shaped in form and content by its *social* context. The latter can only be illuminated by stepping outside of psychology into sociology, social history and economics.

These problems are outlined in this form to present the essence [184] of my argument (that psychologists may not be as well placed as they often assume they are to study psychotherapy). However, such a presentation is rather general and certainly without supporting arguments. To concretise the presentation, I will outline a piece of research I carried out alone (a relevant point) into the practice of National Health Service (NHS) psychotherapy. A full version of this research is written up as my Ph.D. thesis (Pilgrim 1986). However what I outline below is a précis of the research along with some confessions not fully expressed in the formal write-up. (I assume that all formal accounts within the academic discourse contain these subtexts, whether or not they are subsequently revealed.)

#### AN OUTLINE OF THE STUDY

In the early stages of the research my intention was to try to investigate something of the rhetoric of the therapists, i.e. whether or not therapists do what they claim to do in theory, or in *post hoc*

accounts of their work with clients. At the time (1982), I was working in a regional NHS psychotherapy unit outside of London, as a clinical psychologist. What preoccupied me, and the subjects I began to have exploratory negotiations with, to the point of distraction from my original intentions, were wider and deeper aspects of the role of state-employed therapists in Britain, outside of London, operating in a mental health service undergoing structural changes and inheriting intra- and inter-professional tensions. Thus the pressing contemporary occupational concerns of my prospective subjects (most of which I shared) shaped the research focus.

At this point I decided to interview therapists about their work in much the same way that an industrial sociologist might collect partial occupational biographies in order to clarify the day to day functioning of a trade or profession (see Benyon 1970; Bertaux and Bertaux-Wiame 1981). The problem for me was that I was not a sociologist, and though sympathetic to a biographical perspective on life (as a therapist), I felt uncertain as a research psychologist to proceed using a biographical approach, given that the latter seemed not to be 'proper' science within the discourse of my core training. Thus I felt unskilled in a qualitative approach to research and uncertain about the legitimacy of such an approach. [185]

Whilst my supervisor quickly allayed anxieties in the latter realm, by pointing me to erudite sources and noting the need to negotiate a sympathetic external examiner<sup>1</sup> these tricks of the academic trade could only smooth the path and ensure the correct impression when writing up the research. What still remained was any sense of *genuine* competence in pursuing my research interest.

Nonetheless, I started to interview therapists (nurses, psychologists, and psychiatrists) about their work, whilst at the same time trying to read about the main sources within social psychology and sociology (many of which were untouched in my core training) which had something to say about the relevance of personal accounts in human science. For clarity, although these tasks were carried through concurrently, it may be useful to describe them separately.

I interviewed ten subjects and collected over fifty hours worth of taped material which was transcribed. This process produced three times the number of words in transcribed verbatim accounts that were permissible in terms of thesis length, under university regulations. Consequently substantial editing had to take place to reduce the material down to manageable and permissible proportions, in addition to removing redundancy from the material and disguising names and places. Also, I had to attempt to make sense of the material presented by my interviewees and opted to analyse the themes emerging in my first subjects' sessions. These themes were not indwelling to his account but reflected a negotiation between us, and the *post hoc* interpretive decisions I made about selecting themes and illustrative vignettes of tape (Plummer 1983). At this stage some doubts and guilt remained about the legitimacy of claiming that this constituted proper research.

The (five) themes settled on and pursued with other subjects related to: how the subjects became therapists; the relationship between the therapists and their parent or core profession; the relationships between the three professions; problems in establishing a psychotherapy service in the NHS outside of London; and the impact of particular clinical settings on the practice of therapists. What was touched on by the subjects, but I did not ask them to elaborate, was the minutiae of their work with patients. This represented such a large area, that it seemed to constitute a research topic in itself and was, therefore, [186] unmanageable within the limits of a Ph.D. which, by now, was pursuing the occupational, professional, and organisational aspects of

a sub-system of the mental health service in Britain, at a particular historical juncture. I will now outline the concurrent task of reading the existing sources on biographical material, personal accounts, and ordinary language or common-sense emphases in social psychology and sociology. This task eventually was transformed into a review of the personal account research for the thesis but in practice the final approach ('dialectical reasoning' below) was of use to me in the main. The others either emphasise ordinary accounts of motivation (Peters 1959), or emphasise the need to situate or contextualise accounts (Mills 1940), or justify the central legitimacy of personal accounts for human science (Harré and Secord 1972; Garfinkel 1967; Cicourel 1974). These guidelines and bases for justifying the research's legitimacy were important in an overall sense, but impinged little on my awareness when conducting the interviews and analysing or interpreting and editing the data.

As a clinician social-psychological, sociological, and anthropological sources were mainly new and were always challenging if not trying. (This is not a case of personal special pleading but is an acknowledgement that the academic sub-division of labour (Braverman 1974) tends to lead to uncertainty and challenge, when a researcher strays over their own professional boundary into other bodies of knowledge.) Nonetheless, the work of Sartre and Geertz did seem to offer the real basis of making sense of my research focus, in such a way, that a coherent, and hopefully useful, account of NHS psychotherapy could be given. What Sartre and Geertz advocate is a research process that entails tacking to and fro between personal accounts and their social context. This process facilitates the reciprocal understanding of the context from the account and the account from the context.

If such a precarious task is adjudged to have been carried through successfully, then an understanding of both the subjective life of actors in the world and objective aspects of their world are enriched. This process of enrichment or illumination redefines research goals away from generating knowledge claims based upon hypothesis testing, within the traditional empiricist-positivist paradigm. Moreover, the emphasis on context pre-empts, arguably, the charge against personal accounts research of being [187] individualistic or homocentric (see Lemert 1979). Accounts are only seemingly individualistic because, provided that they are situated or contextualised, they, or their narrators, can be used as paradigms or prototypes, which can be used through interpretation, to uncover common discursive and organisational aspects of a shared social reality.

Returning then to the details of this particular piece of research, how did the orientation of Geertz and Sartre help me? Essentially, I took the five main themes about the working lives of the therapists (noted above), and alternated attention between my primary source (the accounts) and secondary sources, which provided me with some knowledge of the supra-personal features of the world inhabited by the narrators. These secondary sources included: social histories of British psychiatry, psychology, and nursing; writings on the sociology of the professions; official publications of the three professions under investigation; material on social and economic changes in post-war welfarism; publications on mental health reform, and the balance between biological and psychological approaches to treatment. The conclusions I drew from this process of oscillating between psychotherapy and its modern NHS context can be summarised as follows:

1. The core mental health professions contain psychotherapy in ways which both advocate its practice and development, and inhibit them. The dominance of biological models in British psychiatry and methodological empiricism in clinical psychology have marginalised but not excluded psychotherapy. The professions have integrated psychotherapy in an eclectic way. This

has superseded the purging of it as a humanistic protest by medicine, and its derision as pre-scientific by psychology, during the 1960s.

2. Psychotherapy is the focus of both intra- and inter-professional conflicts both in terms of its legitimacy as a psychiatric treatment, and in terms of its managerial regulation. In particular the role of medical dominance in the NHS is a vital political factor when understanding the control of psychotherapy. However, the dominance of the medical profession inside the mental health services is being subverted presently by the increased professionalisation of psychology and by the loss of the territorial base of the Victorian asylum. The latter is being phased out in most [188] localities. Where funded, the new mental health facilities in the community are becoming the focus of ideological and professional tensions.

3. Large variations exist between localities in the provision of NHS psychotherapy and the bulk of such provision is in the metropolis. Since the mid-1970s however, there has been a gradual expansion in the stock of psychotherapeutic knowledge in the NHS.

4. An ideological tension exists in Britain between private and NHS practice. Whilst the former is more likely to provide more appropriate setting conditions conducive to the proper practice of psychotherapy, many practitioners opt to work in the public sector. In the light of a psychoanalytical ghetto emerging in London, following the pre-war entry of the Freuds and Klein, even NHS psychotherapy is tilted in availability towards London, with many consultant psychotherapists working in the NHS part time in addition to their private practice.

5. Given the traditional structural dependency of nursing on medicine, where nurses have developed psychotherapeutic skills, they have tended to follow medical leads. This is true both in terms of their employing medically-managed structures and in terms of who trained them. As with other health practices, the impression is one of nursing following the professional contours of medicine.

6. In contrast to nursing, the newer profession of clinical psychology has followed medical contours less. As it possesses an alternative body of knowledge, psychology has represented a greater challenge to medical hegemony. Following a brief period of initial dependency, clinical psychology developed professionally in an autonomous direction, which culminated in repeated disputes with the psychiatric profession.

7. Changes in mental health policy since the nineteenth century have altered the degree of legitimacy enjoyed by 'softer' forms of social control, such as psychotherapy. In Victorian times, more treatment (the precursor of psychotherapy) fitted badly with the custodial regime of the State asylum. Instead, a bio-determinist model in psychiatry, with its treatments acting upon the bodies of emotional deviants, fitted better with the policy of warehousing the mad. At this stage, the marginalisation of psychological approaches within psychiatry was functional for this state-funded and directed warehousing policy and for the development of [189] medical dominance. (An epistemology which asserted bio-determinism gave power exclusively to medical practitioners.)

Subsequently, in the twentieth century, this mutually rewarding relationship between the medical profession and the State system of custodial management of emotional deviance remained during the inter-war periods in particular, and the biological emphasis within British psychiatry was consolidated. However, during both world wars, psychodynamic approaches within psychiatry came to the fore more in response to the need to treat battle neurosis and the need to sharpen up military selection practices.

After the Second World War, the asylum/bio-determinism relationship temporarily re-stabilised but the costs to welfare capitalism of continuing to warehouse deviance began to be

too great for the state to bear. Gradually policies developed advocating hospital run own. Despite 'community care' policies dominating governmental thinking over the past thirty years, it is only very recently, in the context of a deep and lengthy economic recession, that health authorities are saving money by closing down psychiatric hospitals. In this contemporary context, psychotherapists are embroiled, as a result of organisational inertia, in intra- and inter-professional disputes (noted above) and yet are facing a future in which their knowledge may be deployed more than in the psychiatric hospital, when, and if, community mental health projects are funded.

8. The deductions made, by tacking between therapists accounts and secondary sources of knowledge, could be enriched by further research, which takes accounts from other interested parties, such as patients and even staff antagonistic to the practice of psychotherapy.

On the basis of the outlined conclusions drawn above, at the end of the research (1986), I tried to make tentative predictions about the future of NHS psychotherapy (in the knowledge that making predictions outside of the laboratory is risky).

## DISCUSSION

Having outlined, in an inevitably sketchy manner, for reasons of space, the content and process of the piece of research, I would now like to explore some wider reflections arising during and [190] following its completion. Returning to the points made at the outset, I experienced insecurity on all three counts as a consequence of being a British psychologist attempting to make sense of psychotherapy in its social context. My basic academic training in undergraduate and clinical psychology had provided me neither with the skills nor confidence to pursue research which could examine reflexively my own professional culture. Moreover) the state of the art of psychotherapy research itself had only relatively recently recognised the need to sharpen up qualitative exploration of the processes within therapy. This newer research did not extend to exploring the actual context of therapy, although a few recognised that psychotherapy did not take place in a vacuum (e.g. Berman and Segal 1982).

Although I was comfortable with a phenomenological and interpretive approach to decoding the accounts of psychotherapy clients, this did not generalise to using such an approach to understand fellow therapists as an occupational peer group working in an organisational context involved in substantial reform. This seems to indicate that despite the reflexive potential of phenomenology and hermeneutical systems rooted in depth psychology, such reflexivity is severely limited. As Ferraroti (1981) has noted, a biographical approach to understanding society involves methodologies which go beyond the individual to groups of peers (neighbours, work colleagues, families, etc.), and must invoke knowledge of supra-personal features of their situating time and place.

The psychotherapies are themselves predicated on the lengthy study of biographical material but tend to negotiate its understanding primarily with individuals in the consulting room, rather than with groups of individuals in a shared daily living context. Moreover, hermeneutical systems derived from depth psychology, as well as being preoccupied by the understanding of the psyche via a diadic therapeutic relationship, have *a priori* assumptions about the context of the client, which predominantly are in the past (childhood), and are limited by the boundaries of a theory-constructed context (the nuclear family). In the non-psychodynamic traditions of therapy, such as Rogers' client-centred approach, there is a preoccupation with the facilitative conditions for individual growth. Thus phenomenological and hermeneutic systems underpinning varieties of psychotherapeutic [191] practice have collectively contributed to the construction of

individual mental distress. The centring of attention on individual psychopathology and the more general reification of the individual thus produces practitioners who are psychologically sophisticated and sociologically weak or incompetent in their analyses of distress-in-context. Psychological reductionism thus becomes an occupational hazard for the psychotherapist. To make my position clear on this, I should emphasise that phenomenological and hermeneutical strategies help therapists understand their clients but they do not enable therapists to understand their own practice in a socio-political context. Whilst Freud's reification of the family, Jung's reification of the self within the individual, and Rogers' interest in individual potential may have provided therapists with working guidelines for their therapy, they are limited in accounting for the very existence at a particular time and place of psychotherapeutic practice. Whilst not wanting to detract from the genuine wisdom and ameliorative advantages, implicit to psychotherapeutic theory and practice, for the human condition, it has to be acknowledged that they have little or nothing to say about the social determination of their own existence. When attempts are made to trace the roots of practising therapy, psychologistic reasoning is put forward (for instance, in the notion of the 'wounded healer' or the 'helping profession syndrome' (Pilgrim 1987)). Such psychological reductionism can only be pre-empted by attempting instead to develop a sociology of psychotherapeutic knowledge. The most coherent attempt to date of this sort, with regard to psychotherapy and personality theory, is *Self and Social Context* (Holland 1978). (A related corrective to psychotherapeutic enthusiasm and reductionism is *Social Amnesia* (Jacoby 1975).)

The reconciliation of the study of the subjective perspective of actors and the study of the social context of those actors is highly problematic. The variety of positions within the social sciences, which emphasise objectivity on one side and subjectivity on the other (what Marx described as 'false antinomies'), shows the difficulty in generating an academic consensus on the value and weighting to be attached to psychological versus sociological processes and subjective perspectives versus objective conditions, by the two professions. (Although these tensions operate in their most acute form in the human sciences they are also hotly debated [192] in the philosophy of science. For an overview of the positions in the debate between relativism and objectivism, see Bernstein 1983.)

Given the difficulties surrounding reconciling subjective and objective factors, and psychological and sociological processes within personal account research, it is not surprising that there is a significant inertia within British psychology about departing from the certainties entailed in objectivist-positivist methodologies. British psychology has certainly produced *justifications* for personal account research and discursive analysis (e.g. Shotter 1984) but inertia still seems to surround actually doing this type of research. Undergraduate training in psychology for instance does not equip students to be confident in collecting and interpreting accounts, deploying interpretive methods or textual analysis. There exists in other words not only a tradition of methodological empiricism because of our British intellectual culture (Hearnshaw 1964; Anderson 1969) but also, in consequence, a poor stock of knowledge about alternative research methods. significantly, it took a philosopher (Harré) rather than a psychologist to advocate new methods in Britain within the profession, such is the impact of the past on the present.

Thus a parallel seems to exist, in Britain, between the professional status of a biographical approach to psychiatric treatment (psychotherapy) and a biographical approach to social psychological research. In both cases such an approach is not actually illegitimate but it remains sufficiently marginal to produce a picture of theoretical justifications, but only slow and

tentative practical consequences. Theoreticians, such as Shotter and Harré, may have accumulated a justifiable international reputation, but their impact on the practice of research within Britain is still marginal. Analogously, innovations in psychotherapy such as the object-relations theory of Winnicott and Fairbairn, the therapeutic community experiments in British military hospitals and British anti-psychiatry are more noteworthy for their *international* reputation than their impact on native mental health practices. Psychoanalytical theory and practice have been consistently derogated and derided as being pre-scientific (Eysenck 1952 and since). The therapeutic community movement has been marginal in British psychiatry throughout the post-war period and has now sharply declined (Trauer 1984). As for the anti-psychiatrists, they [193] were expelled from state psychiatry and their ideas rejected by the core of the profession (Cooper 1967). A less charitable interpretation of such events was that the psychiatric radicals chose to seek greener pastures (Ingleby 1987). What then are the lessons to be drawn for psychotherapy research, in the light of the above diverse discussion? They can be sketched as follows:

1. Non-positivist research into psychotherapy is likely to progress in a faltering manner, given that the professional ethos of the British mental health professions (the so-called 'psy-complex') has been dominated in Britain by methodological empiricism in psychology and biological reductionism in medicine. A biographical approach to therapy and research will nonetheless exist, to some degree of lesser or greater marginality, as the scientific excesses of British empiricism continue to provoke a legitimation crisis and a critical response. Such a response has emerged over the past twenty five years, in British psychology and psychiatry, in such an intellectually sophisticated form, that its elimination from the academic discourse is now highly unlikely.
2. If psychotherapy research, using qualitative methods, is to go beyond the limited frame of the therapeutic relationship, then an understanding of the synchronic and diachronic features of that relationship's social context must be pursued, drawing upon bodies of knowledge outside of psychology. As psychotherapy researchers have at last confronted the limits of the positivistic examination of therapeutic process and outcome using quantitative methods (e.g. Elliott 1983), the next step is to enlarge the frame under investigation.

Given the disability accruing from the sub-division of intellectual labour, such a task may be beyond the abilities of psychologists operating alone. A more efficient alternative might be to join with other human scientists (especially in sociology and anthropology) in interdisciplinary projects as a first step towards developing a trans-disciplinary appreciation of psychotherapy in various contemporary contexts. This has two implications for psychotherapy research. First, such an expansion of the frame of investigation would seek a greater contextualised understanding of stasis and change in the lives of distressed people, which includes, but is not limited to, the processes existing inside the therapeutic sessions. Second, an enlargement of the research [194] frame would increase the likelihood of psychotherapy as a social practice being illuminated, as connections would be made with the therapy's situating and sustaining context.

3. If psychologists are to participate efficiently in such projects, then their own basic training will need reforming. In particular, a shift from the manipulation of variables in a closed-system experimental or observational framework, to the uncertainties of open stems research will require new skills and assumptions. As has been noted above, there is no lack of recognition of such a need, at the theoretical level, within versions of social psychology. What may be needed now is a form of education for psychologists which facilitates *practical skills* in conducting field

research. In the light of the importance of participant observation experience, it may be that the age of the student and their extra-academic life experience may influence the facility with which they can go on, as a researcher, to cope with a particular area of investigation.

4. Related to these educational implications about skills is a further point about value-engagement and *a priori* assumptions held by researchers. In Britain, as academic and applied psychology have become increasingly professionalised in the second half of this century, legitimacy and scientificity have become almost synonymous. The British empiricist definition of scientificity, by and large, is predicated on the rules and rituals of the natural sciences. Given that until relatively recently, even sociologists of scientific knowledge have been content to follow their founding fathers (Marx and Durkheim) in pursuing value analysis in the *Geisteswissenschaften* only (Mulkay 1979), it is a little surprising that psychologists generally have been professionally socialised into assuming that their empiricism clothes them in disinterestedness and neutrality.

If the biographical method is to be properly pursued by psychologists studying psychotherapy, their assumptions and value preferences will require examination and declaration (see Taylor 1979; and Gadamer 1975). This uncovering process itself may need to become a new and vital aspect of psychotherapy research.

A point of departure for this chapter is the role of psych therapy research itself (of old or new paradigm variety) contributing to the individualisation of distress. In the light of my earlier arguments that psychotherapies reify the individual this [195] must surely mean that researching these practices in their own terms further legitimises this process. The extent to which this is true represents an interesting research topic in *itself*. It may be that all cats are grey in the dark if a post- structuralist account of the psy complex is to be accepted, with Victorian moral treatment and modern psychotherapies representing voluntary relationships which merely constitute alternative versions of psychiatric oppression and surveillance (Castel 1983). Notwithstanding my doubts expressed above about therapists being socially blinkered and psychologically reductionist, I still believe that psychotherapy represents a progressive alternative to pills, hypodermics, and electricity. [End of page 195]