

# Counselling and Psychotherapy: Is There a Difference? Does It Matter?

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*The terms 'counselling' and 'psychotherapy' are often employed in a loosely interchangeable way, especially in Australia. Where distinctions are made, there has been little agreement on what each term should cover. This article examines several axes on which 'counselling' might potentially be distinguished from 'psychotherapy'; the most promising basis for such a distinction seems to be whether or not the mode of work attempts to access the unconscious. On this basis, several modalities currently termed 'therapy' would in fact be classed as types of 'counselling', including those modalities of family therapy which aim to engage clients at the level of conscious behaviour change and restructuring. Consideration of how new professionals are trained lends support to a continuum, with short-term, problem-focused conscious-oriented approaches at one end, and longer-term, transference-focused, unconscious-oriented approaches at the other, the dividing line coming at the point where trainees learn the skill of 'immediacy'.*

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## WHAT'S IN A NAME?

Some years ago, the American Association of Marriage and Family Counsellors changed its name to the American Association of Marriage and Family Therapists. The Australian Association debated whether to make a similar change, but did not end up doing so at that time. Australian Marriage Guidance sidestepped the issue by renaming itself Relationships Australia. When the AAMFC was formed, the term 'counsellor' had dignity. Marriage counselling agencies trained 'counsellors', often lay people without degrees. When I undertook such training, in 1976, I was in the company of individuals most of whom had helping roles in the community, though few of them held professional positions. 'Counselling' (Carl Rogers advocated the term in the US in the 1940s and 1950s because to him it indicated a more humane and client-centred stance than 'clinical psychology' or 'psychotherapy') was seen as a desirable activity by all of them. We learned empathy, active listening and a grab-bag of humanistic and expressive (cathartic) techniques derived from Gestalt therapy and psychodrama. Nobody told us that as 'counsellors' we ought not to be doing such 'deep' work. Still in thrall to the Human Potential Movement, our trainers trusted us with the state-of-the-art helping technologies of the time. (All technologies tend to slip through the boundaries and restrictions placed upon them, and helping technologies are no exception.)

When I sought further training in the US in 1979, I found a very different scene. Now there was 'therapy' and 'counselling'—a distinction that Australians seemed

to feel uncomfortable making. My university offered two programs: a shorter Master of Education award in 'Counselling', and a longer Master of Arts award in Counselling Psychology, aiming to train 'psychologists' for clinical positions in Community Mental Health, where they would often be doing 'psychotherapy'. Everyone seemed to know what the difference between 'counselling' and 'psychotherapy' was, although exactly what it consisted in was rarely addressed. An introductory course called 'The Roles of Counsellor and Therapist' set *Impact and Change: A Study of Counseling Relationships* (Kell and Mueller, 1966). The 'counselling' in this book seemed to have a lot to do with transference (though that term was not employed) and stressed the counsellor's 'use of the counsellor–client relationship'—things that had rarely been mentioned in my Australian training in 'counselling'. On the other hand, Family Therapy, my chosen specialty and enthusiasm back then, was 'therapy', despite the fact that most family therapists at the time rejected the whole idea of transference (for an exception, see Box, 1998), gave their clients straightforward behavioural homework and checked to see if they did it. How was this different from the 'educational' approaches in which my friends enrolled in the M.Ed. program were being trained? I did not fully sort out these things during my two years in the US. I returned in 1981 to an Australia still largely committed to 'counselling', only to see it adopt the term 'therapy' with remarkable speed over the next decade (the insistence of family therapists on calling themselves that, rather than 'family counsellors', no doubt being a contributing factor). Clearly, 'psychotherapy' is now regarded within the profession (and increasingly will be regarded outside it) as the more prestigious term: but what makes it so? A status distinction has arisen without any corresponding thinking-through of the content of that distinction.

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The coming into being of PACFA (Psychotherapy and Counselling Federation of Australia) has simply highlighted something that has, in fact, been a difficult and contentious issue for many years. Are the 'psychotherapy' and 'counselling' enshrined in PACFA's name equal but different? Or are they 'unequal but the same' (performing identical functions, but under more, or less, prestigious labels?) If we cannot, any longer, use the term 'counselling' to denote both activities, then how are we to tell our students what the difference is (or should be)? Even within the three year process leading to the formation of PACFA, that particular difference was either not addressed at all, or rapidly skated over, since the aim was to keep a heterogeneous group ranging from psychoanalytic psychotherapists to telephone counsellors together in the proposed national professional body, avoiding the split into separate associations for 'counsellors' and 'psychotherapists' that had distinguished the comparable process in the UK. Instead, what seemed to happen within the Standing Conferences that gave birth to PACFA was that many participants adopted the nomenclature 'counselling-and-psychotherapy' as a sort of generic category. Although I am far from satisfied with that solution, I have for pragmatic reasons adopted it here, and speak of 'counselling or psychotherapy' whenever I am speaking of the common ground I believe the two share. But what about the ground that is not in common?

### **COUNSELLING WITHOUT THERAPY: DOES IT MAKE SENSE?**

As it has become increasingly clear that, like it or not, we are stuck with two categories, not one, I have pondered possible bases for a valid distinction between the two, and canvassed many possibilities. In particular, I have looked for a possible distinction based on function as well as form, since function seems to cut deeper than form. Such a distinction is also consistent with my longstanding conviction that counselling or psychotherapy is best seen as a specific set of skills and understandings which may be practised across many different helping professions, rather than being 'owned by' any one of them. Clearly, psychiatrists, social workers, psychologists and ministers of religion (to name just a few) may perform the functions of psychotherapy or counselling; nurses, welfare workers, teachers and others may also do so, though this will probably be less likely, under normal circumstances. Despite its increasingly vocal insistence that it is sole occupant of the territory, the discipline of psychology does not 'own' counselling and psychotherapy, nor counselling and psychotherapy training.

This has been demonstrated, pragmatically, by the emergence of counselling as a distinct university discipline—separate not only from psychology, but also from education, nursing, and other professional studies. As a university lecturer in counselling, developing curricula and evaluating assignments, I taught students from the whole range of backgrounds mentioned above. The only thing they had in common was that all of them were in one way or another 'doing counselling' (which might, in

fact, have been 'therapy', depending on how one defined it!). The program had come into existence, as comparable programs in this country have tended to do, partly because of the existence of a large, clamorous market for counselling training that did *not* demand a psychology background. The word 'counselling' had been chosen to designate it because it was still the word that most Australians associated with the functions being taught, and (I imagine) because it sounded less threatening to academics than 'psychotherapy'. It would also, in my opinion, be true to say that most of those who set up the program had not spent much time or energy pondering the difference between psychotherapy and counselling. But at all events, a whole degree program in counselling did, *de facto*, claim professional discipline status for the subject (whatever, exactly, that was!) and with that status came the pressure to define and justify the discipline, against fierce attacks from a psychology department who saw it as a direct threat, and from those in health studies, who insisted that counselling was 'just listening' or 'providing information to patients about HIV/AIDS' (that, presumably, being the only subject on which 'patients' might need information).

Teaching brought me face to face, yet again, with the contradictions and paradoxes of a concept of counselling that did not include, or allude to, a concept of psychotherapy. Our students were trained, like so many, on Egan's Skilled Helper model (Egan, 1996). In the introductory course, our staff graded videotaped sessions as satisfactory if the students listened empathically, paraphrased sensitively and often, asked few questions, and allowed themselves to be guided by their client's agenda. This was called 'helping the client tell his/her story' (Egan, 1996). But if the client were personality disordered, mentally ill, developmentally disabled, or sociopathic, the same criteria still applied. An appallingly inappropriate interview could still gain the student a high mark, because the student did not perceive the level or type of pathology he/she was confronted with, nor (I regret to say) did the marker always perceive it either. Conversely, an interview with a normal client, which contained a high proportion of questions and interpretative statements, even if quite empathic, highly insightful, and well received by the client, tended to be rated very low. Many experienced and competent therapists would have come close to failing our assessment requirements if they had been undertaking our program!

When I offered feedback to students, many of whom were quite experienced and sometimes very good at what they did, the type of feedback that was most enthusiastically received was the kind that went well beyond the level of the counselling microskills (e.g. Brammer, 1993; Ivey, 1988) they were being taught—for example, interpretations of what the client might be unconsciously communicating to them (Holmes, 1998). But by rights, I ought not to have shared this insight with them, ought I?

When I taught final semester students a course in relationship counselling, the systemic understandings I was presenting were not really compatible with the Egan-style approach they had previously learned—yet Egan's model

would not have prepared them adequately to handle a difficult couple. So what should I have taught them? Worst of all, our program involved teaching only the skills and interventions appropriate to the beginning of a professional helping relationship. Our program of study (as it then was) did not effectively support longer term work. We were training students to see clients between one and three times. I sincerely hope the program has changed since.

Yet the experience of teaching counselling was very fruitful for me, and I think it was fruitful for many of our students as well, despite all the deficiencies and contradictions outlined above. Gradually, I came to see that listening well is fundamental to everything else, and that if one encourages students prematurely to question and interpret, one runs the risk of supporting narcissistic and exploitive styles of *relating to* clients, just as *only* listening may in its turn encourage narcissistic and exploitive styles *in* clients. Teaching 'counselling' helped me to see the genuine strengths, and the real limitations, of *an approach to helping which largely ignores the unconscious*. It reminded me that I and some of my family therapy colleagues, trained to use powerful techniques grounded in an intellectual understanding of how human systems operate, had sometimes lost their clients because of their lack of ability to create a sufficiently strong therapeutic alliance first. Teaching counselling also prompted me to discard much of the impressive but questionable rhetoric that surrounds both counselling and therapy (of whatever modality) and to cut beneath it to what counselling and therapy actually *do*. This article is the result.

## COUNSELLING VS THERAPY: POSSIBLE DISTINCTIONS

How might we distinguish 'counselling' from 'psychotherapy', across a range of relevant criteria, in a way that does not denigrate either activity? Let me begin by posing some possible distinguishing criteria, and then examine how well they would work in practice. Laypeople, as we all know to our cost, equate counselling with giving advice. That is, in a way, excusable, because the word 'counsellor' originally meant 'advisor'. Moreover, the rapidly-growing popularity in the media of the verb 'to counsel' (as in, 'The survivors of the tragedy were immediately counselled') reinforces the identification of counselling with something active and interventive: someone *does something* ('counselling') *to you*.

### Counselling as Information-Provision?

Basic counsellor training (e.g. Geldard, 1993), still under the spell of Rogers' 1930s concept of non-directiveness, often rejects the advice-giving function, stressing the counsellor's role as facilitator of client-determined change or as clarifier of options. The rejection of advice-giving is part of the more general rejection of counselling as an instrument of power, social control or social influence. (It is also, of course, in many ways a re-invention of the psychoanalytic concepts of neutrality and 'abstinence',

although few counsellors acknowledge that or even know it.) But in fact, it does not take long to see how the non-directive position is untenable in practice. Counsellors do influence their clients, however 'client-centred' they may think they are. Any intervention whatsoever which directs a client to examine his or her own 'process' or 'inner world' more intently than he/she would otherwise do, is a social influence, and in fact helps to move our whole society more towards what Dumont (1977) calls the 'modern ideology' (which stresses the rights, needs and experiences of the individual human as opposed to collective obligations and loyalties to the *gemeinschaft*). To my mind, a claim that 'counselling' can be distinguished as that mode of helping which rejects direct advice giving, and focuses on assisting individuals to 'come to their own decisions' is invalid, and ethically suspect to the extent that it is actually subverting what it claims to be doing.

Counsellor trainees from non Western cultural backgrounds often feel uncomfortable with the rejection of advice-giving, which in their cultures is an expected part of going for help to someone in authority. *But so too do those in our own culture who belong to more traditional family, community and church structures*, where 'help' is seen as 'being guided in the correct path' by those with kin or community or spiritual authority ('God wants you to work harder at your marriage, Judy'). Such attitudes are found among rural people, as well as among urban fundamentalists of many persuasions, and among many older people, regardless of their location or religious beliefs. These examples assist us to see the social shift involved: the non-directive ideology adopted by Rogers and his followers actually moved us away from the direct link between 'helping' and authoritative social structures, towards a democratic position in which (theoretically) individuals feel empowered to exercise whatever option they feel is good for them, regardless of what society may think. Cushman is simply the latest of many critics (Lasch, 1978; Schur, 1981) to tell us that this democratic, pluralistic individualism can all too easily become the unconscious tool of social forces (principally capitalist economic structures) which encourage an 'empty self' to be filled with longings and needs akin to those defined for us by advertising (Cushman, 1995). Counselling, psychotherapy and the whole gamut of personal growth experiences cater to this emotional 'market'. (The adoption of the term 'customer' in solution-focused therapy to replace 'client' is an eloquent testimony to this.) Counselling may reject 'advice giving' but it cannot therefore escape being a potent social influence.

Just as strong as the tradition that counselling is 'non-directive' is the (contradictory) conviction that counselling is 'educational' in nature. Part of the thinking behind the distinction between the two Masters programs offered by my university in the US, and many others, was a concept of counselling as *providing support and information to particular client groups*. Thus adolescents needed vocational counselling; women with unwanted pregnancies needed abortion counselling; substance-abusers needed addictions counselling to educate them about the harmful effects of the substances they ingested, and to confront them firmly with their evasions and denials. What is the difference

between this 'educational' counselling and 'advice giving'? Proponents of educational counselling would claim that they are not 'telling people how they should live' (as in traditional societies) but rather, 'providing information which clients are free to accept or reject as they choose' (which appears to fit with non-directiveness and 'clarifying options'). However, the very choice of areas where such information provision is deemed necessary in itself points to moral discriminations already made by society, to the problematising of certain behaviours rather than others. Thus unwanted pregnancies are a problem that requires 'counselling'—but exploitive promiscuity is not; drink driving does—but not 'social' drinking, and so on. It begins to look as if, in popular usage, 'counselling' is something that is provided to involuntary clients, either those who have transgressed some social rule, or those who have been innocently caught up in some mass trauma (train smash, public shooting, etc.). In both cases, the assumption is that a social control function is involved (not dissimilar to the health system's adoption of the term 'management', in phrases like 'pain management' and 'grief management').

If we cannot claim that the rejection of advice giving is something that characterises 'counselling', then is it, nevertheless, a basis for establishing a distinction between counselling and therapy? I fear not. Both counsellors and therapists are in fact agents of social influence: that much is clear. Both operate within the 'modern ideology'. Advice giving is possible in both, even though the ideology of counselling may reject it, and the doctrine of psychoanalytic psychotherapy might see it as representing the therapist's failure to resist seduction. It is even possible to suggest that in certain conditions, psychotherapists might feel readier to offer direct advice to their clients than counsellors. A therapist might feel freer to offer direct advice to a client simply because she knew that client intimately over many sessions, and had information about many different areas of that client's living and relating. Under those circumstances, a therapist might indeed function somewhat more like a traditional authority figure, telling a client what was good for him/her, how he/she would be best advised to react to challenges in his/her life, even though it is still by no means certain that the therapist might not do damage by advising a client inappropriately or unethically, or by advising him/her at all).

There is another way in which a psychotherapist may operate more like an authoritative helper in a traditional society, and that is in his or her willingness to 'assess', 'diagnose' and 'treatment plan'. These functions, taken over from the medical model within which psychoanalysis (and hence, later, psychoanalytic psychotherapy) originated, all assume a degree of expert standing on the part of the helper, and are a far cry from the rejection of labelling and diagnosing which characterised Rogers' approach to counselling (and which latterly has been adopted by Narrative therapists). Strategic therapists, at least those who defined and popularised the notion of strategic work (like Jay Haley) often reject diagnosing and labelling as irrelevant or dangerous, but nevertheless

makes conscious, deliberate use of clients's expectations of authoritative advice by prescribing homework, often with a paradoxical flavour, and in offering authoritative reframes and positive connoting of problematic client behaviour, in the interests of catalysing change. Some of the same stance continues in the brief, solution focused tradition, even while some of its proponents explicitly reject the aura of manipulativeness and expert power (O'Hanlon, 1999).

Is there a difference between such an interpretation of advice giving and the meaning Rogers or his followers would have attributed to it? I think there is. The strategic therapist consciously stands *outside* the role of expert, recognising what the client will *expect* of the 'expert', and playing along with those expectations, while simultaneously subverting them by failing to give the straightforward advice ('more of the same wrong solution') that a less experienced campaigner would offer.

Difficulties arise when such approaches (e.g. White's, de Shazer's, Madanes') are taught to trainees unskilled in other approaches to helping, and ignorant of the clinical wisdom and years of experience that the founders of strategic schools have accumulated. The result is that, in a sense, therapy ceases to be therapy and becomes something akin to 'advice giving', in the sense that the newly trained helper doles out the recipe as he/she understands it, using the framework he/she has been taught as a container for his/her own anxiety, clinging as rigidly to that framework as the clients cling to their problem. The meta-position implicit in the original assumption of the 'expert' role has been undermined, and the whole nature of the enterprise has been altered.

### **Counselling for the 'Worried Well', Therapy for the 'Sick'?**

Another axis on which it has sometimes seemed possible to distinguish counselling from psychotherapy is one that refers to degree of 'pathology' in clients. Those who trained me in the US taught that 'counselling' approaches are suited to what the DSM II called 'adjustment reactions', that is, to normal people under stress; in cases of more rigid personality structure and more far-reaching psychic damage, what was needed was 'therapy', which had as its aim 'restructuring of the personality' (a grand term which I suspect was rarely actualised, then or now). There was some truth in this formula. Relatively resilient clients (I refer here to the concept of temperamental resiliency: see Dugan and Coles, 1989) whose lives are basically on track do often respond well to direct advice (which they have sufficient ego-strength to evaluate realistically and to reject if it fails to fit their circumstances and values). Paradoxically, however, they may respond equally well to approaches which assist them to look within and find their own solutions. By contrast, less resilient clients are more vulnerable to manipulation via 'authoritarian' advice-giving (they may swallow it whole) or prone to reject it without considering it rationally at all (vomit it up).

However, yet another paradox now looms. While the more rigid and damaged clients in the 'middle range' of

the spectrum of wellness–pathology may be more appropriately offered psychotherapy than counselling, the most impaired of all (those with a mental illness, or a serious personality disorder) are not, in many cases, open to psychotherapy. Hence Freud's pronouncement that psychoanalysis was not suited to psychotics (Freud, 1933); Indeed, the approaches that seem to work best with such clients (whether their practitioners acknowledge it or not) combine patient acceptance and empathy with direct provision of information and 'coaching' on appropriate behaviour in particular situations—something not very different from what works best with the 'worried well! This approach may be termed 'supportive therapy', but in fact it might just as well be called 'supportive counselling'. The modifications in traditional psychoanalytic methods suggested by Kohut (1971) and Masterson (1973) on the basis of extensive experience with personality disordered clients amount, in some ways, to a reinstatement or rediscovery of Rogerian principles, and a recognition that such clients are simply not open to classic transference-interpretation interventions, or to any kind of confrontation that has not been preceded by lengthy provision of 'perfect mirroring' by the therapist.

A common sense reading of the history of psychotherapy tells us that *all* modalities and approaches seem to work best with the healthiest clients (who are the most likely to get better anyway, with or without any professional intervention) and all work *least* well with those who suffer from a psychosis. Virtually *every* major new modality (from Client-centred through Milan systemic to Narrative) begins by claiming 'miraculous' cures for schizophrenia, and ends by admitting that such results are not sustained (Selvini-Palazzoli, Cirillo, Selvini and Sorrentino 1989: 9): the 'cure' proves to have been a function, not of the theory or the technique, but of the newly-converted therapist's *belief* in theory or technique, which transmits itself (at least temporarily) to the client! So great is the faith, in the early days of any new modality, that it will even achieve transformations of seemingly impossible problems (Totman, 1979). Perhaps the miracles of Jesus exhibit the same principle. We cannot, then, distinguish counselling from psychotherapy on the basis of which segment of the health–pathology continuum they have been found most useful in treating.

### Counselling for the Conscious, Therapy for the Unconscious?

A more fruitful basis for a counselling/psychotherapy distinction seems to me to lie in *whether or not the unconscious is addressed*. To therapists of a psychoanalytic persuasion, this will seem crashingly obvious, but it will not be as obvious to family therapists, whose intellectual tradition has been ambivalent as to the usefulness (Haley, 1976), or even the existence, of an 'unconscious' (for example, there is no entry for the latter term in the index to Hoffman's influential 1981 text).

It is my observation that counselling approaches, as commonly taught and practised, tend most often to engage clients at a conscious level. While 'active listening'

and empathic paraphrasing encourage clients to explore their inner worlds, and while this often leads to the articulating of material that an analyst might wish to interpret in terms of unconscious dynamics, in fact *such interpretation does not occur* within the classic counselling approach. Rogers avoided it, as part of his general avoidance of the 'expert' role, with its accompanying power differential. To be sure, Rogers himself did 'interpret' on occasion (Farber and Raskin, 1996). Many instances of the counselling microskill sometimes called 'advanced accurate empathy' are in fact interpretations under another name. Though they may go a little beyond the client's conscious awareness at the time, however they do not offer readings of the 'deep unconscious' (Langs, 1996). To do so would require sensitive translating of the client's narratives about 'other people out there' into tactfully-phrased statements of how the client feels towards the therapist right now, which, in turn, encapsulates information about the 'there and then'—feelings towards significant others in the client's past (Scharf and Scharf, 1998).

It is that sustained engagement with the deep unconscious, which, Langs argues, communicates *only* through 'stories' and *only* at a symbolic level, which has a strong claim to being one of the distinguishing marks of true psychotherapy. This engagement makes possible continuing work with the therapist–client relationship. Such work may take the form of occasional use of 'immediacy' (a microskill that consists in the counsellor's acknowledging the unvoiced but conscious here-and-now feelings in the relationship), at the level of an *unfolding sequence* of strong feelings that a patient *unknowingly* experiences in relation to a therapist. With care and good timing, the therapist may be able to interpret these responses in such a way that the previously unowned, warded off feelings are gradually incorporated into the client's conscious self and recognised for what they are.

What is also implicit in accessing unconscious material is a sophisticated conception of resistance to change, that is, that all of us may find ourselves sabotaging our own attempts to reach states that we claim we ardently desire. Such a concept of resistance depends on the notion of an unconscious, or at least, on the notion of forces that are outside the normal awareness of individuals. Here, several schools of family therapy resemble the psychodynamic individual therapies in their attention to 'systemic resistance' and their attempts to address it overtly, whereas counselling normally does not (e.g. Reimers, 1999).

But, while psychoanalytically-derived psychotherapy may be distinguished from counselling on such grounds, where does that leave those forms of family therapy which have not only ignored the unconscious, but also bypassed both transference and resistance? Equally, where does it leave cognitive behavioural therapy, which also bypasses transference and the unconscious in its pursuit of Thought Reform? (There is, in fact, more than a little in common between CBT and the brainwashing practices described by Lifton, 1963). And where does it leave family therapy and CBT that they seem to have so much in common, for all that they seek to achieve it in very different ways?

Could it be that both of these modalities belong with the information-providing, social-control concept that we have established is currently seen as *counselling*? Could it be that Brief Solution-focused Therapy falls into much the same category? When a solution-focused school counsellor (Mooney, 2000) tells a young client distressed about his parents' divorce that 'Saying goodbye to Dad also means saying hello to Dad who lives in a new place and has a girlfriend', is she really offering 'therapy'?

### Close-up or Long Shot?

I would like to suggest an analogy for the difference between counselling and psychotherapy which escapes at least some of the problems we have considered, although it does not solve all of them. It is not a black/white distinction, an 'either/or' categorisation, but recognises that what we are dealing with will always be a continuum, along which modalities, schools, techniques and individual styles may be tentatively placed, but along which any practitioner of any one of them may at times shift, depending on the context of the work, the nature of the client, and so on. The analogy I propose is drawn from the visual arts. Dürer's 1503 painting 'Large piece of turf' (sometimes known as 'Grasses') is a splendidly detailed picture of some clumps of grass. By contrast, his watercolour 'Pond in the woods' (about 1495–7) depicts a medium distance landscape, within which grass in the foreground assumes a much less important role, as part of a larger whole.

I propose that it would make reasonable sense to define *counselling* as like 'Grasses': *close up* work. This means that the problem looms large, and takes precedence over the persons of both client and counsellor. Willy-nilly, the counsellor must focus on the presenting problem to some degree, or he/she will lose the client. While the client's story of frustration or distress can be expanded somewhat, with skilful questioning and empathic responding, there is no time for exploring the entire life that lies behind it (which would be a wide shot), let alone the entire pattern of family relationships or restraining social-cultural contexts that have contributed to maintaining it.

Similarly, though the counsellor–client relationship is important, and transference dynamics may begin to occur, there is no time for them to be addressed in a more than perfunctory manner, perhaps as a way out of a temporary block or resistance to change. To attempt to address them would be either to lose the client, or to alter the frame substantially, inviting the client into a relationship that is not only likely to be longer-term, but also far more intimate. The counsellor will not, normally, become an important figure in the client's life, or a source of lasting social influence. The helper must, automatically, be more selective in his/her focus, 'zooming in' on only a small portion of the whole (as brief and solution focused approaches focus on prior attempts to solve the problem, and on miracle questioning).

This makes it more likely that the helper will conceptualise his/her role either as exploring options and moving clients into action (as in the widely used Egan model)

or as offering information of a psychoeducational nature, and then assisting the client to assimilate and come to terms with its implications. The client as an individual (or the nuclear family as a bounded system) will be in close focus, not the wider system.

At this end of the counselling–psychotherapy continuum the focus cannot really include the counsellor, the 'seeing eye'. He/she will be behind the camera, as it were. The helper must 'join' the client system superficially, in order to have leverage within it, but cannot become a true temporary member of the extended family with the direct moral authority that a long term therapist may have. Instead, the helper relies on either the client's innate power to heal as in Rogers' model, or on the provision of advice/information that is externally validated (as in the psychoeducational model). Either way, the person of the helper is likely to be less important than in longer term work.

By contrast, at the 'therapy' end of the continuum, the 'wide shot', the individual details of the client's presenting problem assume less importance, or blend into a much broader picture, in which history (the individual's personal past and the past of his or her family), social context (societal forces impacting upon the problem), gender, and other factors, can be expanded into subjects of discourse and conscious attention in their own right. Paradoxically, as this happens, the relationship with the helper becomes more, not less, important than in short term 'close up' work. Regardless of whether the helper maintains a strict, psychoanalytic neutrality in order to foster transference, or whether the helper actively shares self with client in an attempt to create a different kind of interpersonal intensity (Rogers, 1961), the relationship continues longer, and bulks larger. The helper becomes a real member of the client's social atom, not merely 'that nice lady we went to see a few times'. This moral authority again puts the long term therapist in a position comparable to that of the helper in traditional societies, with the exception that in our society, the therapist may choose to voice, not the sanctions of the community, but a view subversive of them, as Cushman (1995) points out. In a long-term therapeutic relationship that works, it is ultimately the person of the therapist which will be efficacious and internalised, regardless of the stance she takes, and/or the information she provides, whereas in short term counselling, it is far more likely to be the *information* that functions as the vehicle of efficacy, not the counsellor's person.

In the 'long shot', 'resistance' will take its place, not as an irritating and inexplicable interruption to the smooth progress of change-work, but as understandable, and even predictable, in the wider contexts of the individual's 'deep unconscious', and the out-of-awareness patterning handed down in his or her family.

### SOME MODALITIES RE-CLASSIFIED

As already anticipated, CBT in all of its variants would be classed as counselling under the categorisation I am proposing, since it is overtly psychoeducational, and aims at a combination of insight and behaviour change. At the 'therapy' end of the continuum would, of course, come

psychoanalytic psychotherapy, and neo-Freudian and Jungian models that engage the deep unconscious.

Family therapy, in many of its manifestations, would occupy an intermediate position. Bowenian family therapy for example, adopts a 'wide angle lens' on the presenting problem, proceeds over a lengthy time frame, and acknowledges 'systemic resistance' (thus placing it closer to the psychotherapy end of the continuum), yet it bypasses transference, de-emphasises the client-therapist relationship and coaches clients in behavioural changes (thus putting it closer to counselling). Milan systemic therapy would also occupy an intermediate position. Insofar as it relies on 'interpretations' and 'prescriptions' that speak direct to the unconscious of the system, it falls towards the 'therapy' end of the scale, yet (like other types of family therapy) it may operate over a short time frame, and de-emphasises the therapist-client relationship.

I would place Narrative therapy closer to the 'counselling' approaches on my proposed continuum. Through carefully planned strategic questioning, narrative therapists expand the discourse of selfhood (albeit in particular ways, designed to empower the individual against an externalised 'problem'), but do not engage the client(s) in any exploration of the deep unconscious, or any deepening of the therapeutic relationship itself. Narrative shares with some other brief and strategic approaches a belief that 'resistance' is simply a way of blaming the client for the therapist's lack of empathy or skill. Assisting the client to identify an alternative self narrative, to articulate it more fully, and to publicise it to others, I see as psycho-educational, much as CBT would assist its clients to identify irrational beliefs and to practise ways of interrupting or overriding them. The client's changes lie in his or her ability to assimilate and operationalise the radically new perspective on his/her life and problems provided by the highly selective, focused questioning and responding the therapist provides.

## A PERSPECTIVE FROM TRAINING

To my mind, training predictably and appropriately proceeds from the conscious to the unconscious. Thus, it makes sense that training of new professionals would begin with the development of counselling skills, that is, the active, conscious manipulation of the rules of social conversation so as to expand the discourse of selfhood. Whatever counsellor training manuals and programs say, what basic counsellor training actually does is teach trainee counsellors how to influence clients to say more, rather than less, about their inner worlds. Simultaneously, however, counselling (as I have defined it) tends to *close off* the deepest sources of self knowledge, by its inability to engage the deep unconscious, by offering teaching, in the psychoeducational manner, or by offering 'sharing' within the context of an 'equal' relationship, as some Rogerian-derived and Feminist models (e.g. McLeod, 1993) advocate.

As soon as the training of counsellors reaches the skill of 'immediacy', and a consideration of the here-and-now process between counsellor and client, it moves up on the

line that (to me) divides counselling from psychotherapy. Whether it decisively crosses that line is another matter, and will depend in part on the orientation and knowledge of trainers. If trainers are themselves therapists, then they will, simply by virtue of that fact, automatically communicate to trainees that there are further dimensions to the counsellor-client relationship, even though they may not ever address or articulate those dimensions in class. If trainers themselves have little concept of anything beyond counselling, then naming here-and-now process in the therapy room will not become a vehicle for the exploration of transference or countertransference, let alone projective identification.

Thus I would teach counselling and psychotherapy as a continuum, in which counselling skills form an essential first segment, and which many students will be able to grasp and activate well before they can grasp the psychotherapeutic portion of the continuum. Moreover, counselling skills (as currently conceptualised, and as discussed here) constitute a basis for developing skills necessary to the successful practice of the more directive or 'educational' therapies, which in my system lie near the counselling end of the continuum. At the point where trainees begin to question the limitations of such approaches, a training course should then be in a position to introduce notions of unconscious process, and dynamic interactions between client and worker, and *therapy* can come into focus.

In order for this to happen, another distinction has to be established for trainees. Students relatively new to helping tend (on the whole) to equate empathy with 'being encouraging'. Their responses to clients will include offering praise for clients' 'courage' or risktaking, overt reinforcement for new behavioural steps taken, and so on. There is a general sense of the counsellor being positioned somewhere between a teacher and a parent, with a clear notion of what the client needs, and a program to help her/him get it. Slips backward will be greeted with regret, or compassion. What students of psychotherapy need to learn is that such responses, although helpful in the close up focus of counselling, become less and less helpful in the enterprise of psychotherapy, where the therapist needs to maintain a kind of empathy that does not necessarily depend on offering the client active encouragement and sympathy. Trainees gradually learn that by refraining from such a stance, they create a wider field for client responses, run less risk of therapy becoming a kind of 'thought reform', and open up more areas for the client-therapist relationship to become a major field of therapeutic work.

A sophisticated understanding of the forces that restrain clients from change is crucial to successful psychotherapy, as opposed to counselling. Where a focus on strengths and resources, and the celebration of success, will help many clients, there will be many others whose own systemic fears of change will lead them to become threatened by such straightforward encouragement, which fails to acknowledge and recognise their anxieties about change. Therapeutic approaches that tackle unconscious resistance in a planful manner, by (for example) adopting

a cautious attitude to change, overtly restraining clients from changing, and warning clients of possible backlashes against change, are (in my view) closer to the psychotherapeutic end of the continuum than to the counselling end, since they run counter to commonsense understandings of both clients and therapists-in-training. That it might help a fighting couple more for the therapist to warn them against change than to encourage them to alter dysfunctional relationship patterns is not something that makes immediate sense to the beginner, and it may even seem devious and unethical. Again, I would place the Milan systemic therapies closer the therapy end of the continuum, alongside psychoanalytic therapies, for this reason.

I am sure that the category system I have proposed in this article will not satisfy all readers. In particular, those who already call themselves ‘therapists’ will not welcome any nomenclature under which their approach is to be classified with ‘counselling’. In that respect, whether we teach our clients about ‘irrational thoughts’ or about the nature and needs of their ‘inner child’ makes little difference. But even though many may object to the classifications and criteria I have suggested, I hope that at the very least, they may stimulate readers to think again about a complex and confusing subject, and join in the enterprise of attempting to bring some order to it, if only so that we who train can have something considered to say when students inevitably ask us, ‘But what *is* the difference between counselling and therapy?’

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