

The hope is that this will improve services for patients and keep costs down. The challenge will be to develop new patient pathways that move across primary, secondary and tertiary care, and to improve communication and integration between services for better patient care. The discussion about therapeutic modalities is part of an inter-professional dialogue, and has less relevance to patients and commissioners. Above all is the requirement for leadership and vision, and commitment to reflective practice. With vision and effective clinical leadership there will be opportunities for different kinds of psychological therapies to meet the needs of clients in healthcare settings. ■

Jane Rosoman is Clinical Lead, Primary Care Mental Health and Wellbeing for Ealing Primary Care Trust. She is a board member of the Association of Counsellors and Psychotherapists in Primary Care (CPC) and a trustee of The Metanoia Institute.

References

- 1 www.dh.gov.uk/worldclass commissioning
- 2 Skills for Health. Psychological therapies national occupational standards development project. Frequently asked questions; December 2008. Available via: www.skillsforhealth.org.uk/uploads/page/429/uploadablefile5.pdf Accessed 9.2.09
- 3 Clarkson P. The therapeutic relationship. London: Whurr; 1995.
- 4 Wampold BE. The great psychotherapy debate: models, methods and findings. Mahwah, NJ: Lawrence Erlbaum Associates; 2001.
- 5 Cooper M. Essential research findings in counselling and psychotherapy: the facts are friendly. London: Sage Publications; 2008.
- 6 Houston G, O'Brien M. Integrative therapy: a practitioner's guide. London: Sage Publications; 2000.
- 7 Evans K, Gilbert M. Psychotherapy supervision: an integrative relational approach. Buckingham: Open University Press; 2000.
8. Department of Health. Commissioning IAPT for the whole community. London: Department of Health; 2008.
9. de Shazer S. Clues: investigating solutions in brief therapy. New York: WW Norton; 1988.

Topics in training

After CBT, what future for person-centred counsellors in our health services? asks **Peter Jenkins**



Along with many other training providers of continuing professional development (CPD) courses for qualified counsellors, we have recently noted a flood of applications for short courses in cognitive behaviour therapy (CBT) and brief therapies. Quite apart from pressures arising from accreditation and pending statutory regulation, there seems to be building up a real head of steam pushing counsellors, mainly those trained in the person-centred approach, towards updating their skills for a rapidly changing job market.

The reasons for this shift in the training and job markets are not hard to find. The adoption of clinical governance measures and the increasing reliance on evidence-based practice has decisively tilted the employment market for counsellors towards therapies with a strong and up-to-date research base. Within the rather narrow terms used by the National Institute for Health and Clinical Excellence (NICE), research into proven therapeutic effectiveness has leaned heavily in the direction of CBT (see Table 1). A brief summary of current NICE recommendations for psychological therapies recommends CBT in every major diagnostic category, with the single exception of self-harm/borderline personality disorder. Even here it could be argued that the treatment of choice, dialectical behaviour therapy, is itself a derivative of CBT, rather than representing a completely distinct therapy. The apparent policy tilt towards CBT is further underlined by Lord Layard's recommendations for the development of the programme for Improving Access to Psychological Therapies (IAPT). Here, CBT is strongly positioned, in both low and high-intensity versions as the 'first among equals' in terms of therapeutic preference by service providers.

CPD and the person-centred research agenda

Where does this leave the bulk of counsellors in the health services, who

have often trained in the person-centred approach and who would tend to distrust a reliance on short-term techniques and an emphasis on cognition rather than affect? In the short-term, one effect is the surge in applications for CPD training in brief therapies or CBT, along with a plethora of advertisements for such courses in the counselling press. In the longer term it may have direct implications for the development of the proposed BACP core curriculum for training counsellors, if a classical person-centred initial training is seen to be out of step with the demands of the workplace for a more flexible or integratively trained workforce.

Another effect of this shift can be seen in the urgent redrafting of the research agenda for the person-centred approach and that of other non-CBT therapies. The research agenda has been left for too long to the active researcher-practitioners of the CBT model, at least in regard to empirical research. In an increasingly effective (if belated) rearguard action, research is now emerging that challenges CBT's favoured position as the 'treatment of choice' within the NHS. BACP's recent *Systematic review of counselling in primary care*¹ points to the range of research on the effectiveness of non-CBT therapies, as does the persuasive research case study by Terry Hanley and Isabel Gibbard² into the routine use of person-centred therapy in the NHS.

One of the most interesting developments has been the current theoretical debate that has opened up within the person-centred arena, about the appropriateness of using other 'techniques' within this core model. Influential writers within the UK, such as Mick Cooper and John McLeod, have recently called for a 'pluralist' approach towards developing person-centred research and practice in new ways³. However, others have argued that even recent crucial innovations, such as the concept of 'relational depth', pioneered by Dave Mearns and Mick Cooper, represent a radical 'departure' and break from the person-centred model as such⁴.

Positions in the emerging debate

In this debate, it now seems that there are three distinct positions emerging from within the person-centred 'nation'. For some classical person-centred practitioners, the core conditions as set out by Carl Rogers remain necessary and sufficient without the need for the incorporation of additional techniques or adaptation to externally imposed time restrictions. Even here, there is clearly room for alternative points of view. Roger Casemore, Senior Teaching Fellow and Director of Counselling and Psychotherapy Courses at Warwick University, argues forcefully that 'There is no "one way" of being person-centred'. Casemore's view is that: 'As a classical person-centred therapist, I believe that if I maintain the three central conditions as strongly integrated aspects of my way of being, this gives me the freedom to do many things in a way that is congruent with the underpinning philosophy of the approach' (R Casemore, personal communication 19/12/08).

A second stream can be discerned around the use of experiential or focusing therapies associated with the work of Eugene Gendlin, which arguably have been very responsive

in the past to the integration of other (often time-limited) therapies within the person-centred approach.

Keith Tudor, Director of Temenos in Sheffield and editor of a recent key book, *Brief person-centred therapies*⁵, argues in favour of separating out 'fundamentals' in the debate from 'fundamentalisms'. Tudor refers to 'A third way, by which the practitioner works according to person-centred principles and within the limits and limitations of the therapeutic context. In this way the practitioner maintains a client-centred perspective and resists the use of focusing or directing the client to change or to achieve certain objectives, such as happiness, which are set and researched by external authorities' (K Tudor, personal communication 31/12/08).

So, to return to the original question: what kind of future awaits person-centred counsellors in our health services? It seems that the future may lie with a resurgent, research-based and increasingly flexible form of person-centred practice, which is confident about working effectively within time limits and is not shy about adopting the proven benefits of other models

when these fit with the underpinning philosophy of the person-centred approach. ■

Peter Jenkins is Senior Lecturer in Counselling at the University of Salford, and an Associate Editor of HCPJ.

Acknowledgment: I would like to thank Mary Davis for providing additional background research material on this topic.

References

- Hill A, Brett A, Jenkins P, Hulme C. Counselling in primary care: a systematic review of the evidence. Lutterworth: BACP; 2008.
- Hanley T, Gibbard I. A five year evaluation of the effectiveness of person-centred counselling in routine clinical practice in primary care. *Counselling and Psychotherapy Research*. 2008; 8(4):223-230.
- Cooper M, McLeod J. A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling and Psychotherapy Research*. 2007; 7(3):135-143.
- Wilders S. Relational depth and the person-centred approach. *Person-Centred Quarterly*. February 2007; 1-4.
- Tudor K. (ed) *Brief person-centred therapies*. London: Sage Publications; 2008.

Guideline	Diagnostic category	Recommended treatment
CG22	Anxiety (including panic and generalised anxiety disorder)	CBT/medication/self-help approaches
CG72	Attention deficit hyperactivity disorder	Medication/CBT
CG38	Bipolar disorder	Medication/electroconvulsive therapy/CBT
CG53	Chronic fatigue syndrome	CBT/graded exercise therapy
CG42	Dementia	Structured group cognitive stimulation programme/aromatherapy/music therapy/CBT/reminiscence therapy
CG23	Depression Mild Moderate/severe Chronic	Self-help approaches/exercise/brief CBT CBT/interpersonal psychotherapy/couple-focused therapy/psychodynamic therapy/medication CBT <i>plus</i> medication
CG9	Eating disorder Anorexia nervosa Bulimia nervosa Binge eating disorder	Cognitive analytic therapy/CBT/interpersonal psychotherapy/ psychodynamic therapy/family interventions Self-help approaches/medication/CBT/interpersonal psychotherapy Medication/CBT/interpersonal psychotherapy/dialectical behaviour therapy
CG31	Obsessive compulsive disorder	CBT (group and individual)/exposure and response prevention/medication
CG26	Post traumatic stress disorder	CBT/eye movement desensitisation and reprocessing (EMDR) or medication
CG1	Schizophrenia	Medication/family interventions/CBT (counselling and supportive psychotherapy <i>not</i> recommended)
CG16	Self-harm associated with borderline personality disorder	Dialectical behaviour therapy
	Children	
CG72	Attention deficit hyperactivity disorder	Group-based or individual parent training/education programmes/CBT (individual or group)/medication
CG28	Depression Mild Moderate/severe	Supportive therapy/group CBT/guided self-help CBT/interpersonal psychotherapy /family therapy/child psychotherapy/medication
CG9	Eating disorders Anorexia nervosa Bulimia nervosa	Family interventions CBT
CG31	Obsessive compulsive disorder	CBT/exposure and response prevention/medication
CG26	Post traumatic stress disorder	CBT

Table 1. Summary of NICE treatment recommendations for the use of psychological therapies