Presenting a united front

With debate currently raging around issues such as CBT, the IAPT initiative and the necessity of personal therapy for therapists, one disgruntled BACP member thinks it’s time for us to present a united front and stop arguing amongst ourselves

by Simon Proudluck

An unexpectedly long train journey allowed me to catch up on my reading, in particular issues of therapy today and The Psychologist. December’s therapy today proved an interesting read, and left me feeling bewildered as to what exactly I’ve signed up to be. For me, this issue of the magazine ‘for counselling and psychotherapy professionals’ summarised my impressions of the way the journal has been going, and left me feeling anything but professional.

Simply put, as a profession we seem to be entangled in a never-ending stream of bickering amongst ourselves. Arguing about whose view of counselling is correct – be it about the medical model, cognitive-behaviour therapy (CBT) and the Increasing Access to Psychological Therapies (IAPT) initiative, mandatory personal therapy or which model is best. The pages seem filled with contradictory arguments. Is it any wonder that commissioners, employers and the public have a hard time knowing what counselling is when we seem unable to decide upon a united front ourselves?

Who’s right?
Other professions also have conflict as to which way of working is the best. Psychology, for example, has a variety of subdivisions, all with their different ways of working with people. But it seems for psychology that this variety is celebrated and not criticised – on face value at least psychologists have developed into a position of healthy respect for each other’s perspective. Respect for different opinions is not something I’m picking up from therapy today.

Are we not getting bogged down in something that has very little meaning to the client? I’ve yet to meet a client who shows any great interest in the way we work with them. As long as they start to feel better about their situation, feel listened to and can see some sort of hope for a better future, they believe therapy is working. The same seems true with the current ‘exposé’ on anti-depressants; for those who feel they are working for them, their concern isn’t really with the research but simply that whatever they are taking is making them feel better – sugar pill or SSRI. Can we not simply start looking at psychotherapy in the same manner? Different models help different people. Most clients seem to value the therapeutic relationship as more important than the particular model the counsellor is using.

Please don’t get me wrong, I encourage healthy debate if it’s going to have a productive outcome. In our case though, it seems nothing could be further from the truth. If I was a lay person picking up therapy today for the first time in December hoping to get an insight into what therapy and counselling is all about, I feel I would be more confused than educated.

Another way of working?
For a profession embroiled in the business of change management and exploration we seem stuck in the same ways in which we’ve worked for the last few decades. Instead of fighting the recommendations of the Layard report, embrace them. As Dr David Veale elegantly puts it in February’s therapy today, the Layard report isn’t saying other therapies are ineffective just that CBT has more evidence to say it is effective.

Would it really do you any harm to broaden your therapeutic bag of tools and attend a two-day workshop on CBT? Of course CBT isn’t the answer to everyone’s problems, but Lord Layard did make a couple of good points that got the Department of Health interested – it is backed up with research showing it is effective and it is cost efficient. The ever-increasing demand for psychological therapy equates to a cash-strapped NHS being unable to afford one or two years of therapy. As a country we simply cannot afford this.

As counsellors and psychotherapists we are ambassadors for our profession. Every one of our clients will tell at least one person they are seeing a counsellor. What they tell about their experience of counselling is pivotal in building a more positive perception of counselling and psychotherapy. From the individual in private practice to the profession as a whole, we are poor at marketing ourselves in a way that gets the very people we are trying to help interested in what we are doing. CBT has simply got the nation interested.

Mandatory personal therapy – does it help the client?
If it’s not CBT or the medical model we seem to be bickering over, it is whether personal therapy for all counsellors should be mandatory. Underlying all arguments is the consensus that some form of personal development is necessary before counsellors are allowed to practise. This viewpoint seems to be unanimous, and it is this that we should be enforcing.
The exact form this personal development takes is dependent on the individual. Personally I don’t see the benefit of hours after hours of personal therapy. Yes, there are some individuals who need to process their own personal experiences of life before facilitating the mental re-negotiations of others. But surely after a while of seeing the same therapist it becomes more like two professionals checking in with one another – both counsellor and client becoming comfortable in what seems to be a mutually beneficial relationship.

My own personal development stayed well away from the therapy room and I have yet to feel the need to talk to a personal therapist (and no, I’m not in denial!). Having completed a large part of my training in the USA, my most memorable personal development exercise involved a single trip to a local Alcoholics Anonymous (AA) open meeting. How many of us in our work at some stage have encouraged a client to go to AA? How many of us have put ourselves in the position of that client and gone along to a meeting?

Personal development is an integral part of counsellor development. But I can’t help but be suspicious of a profession where a majority of courses seem to force its budding professionals to become the client and pay for hours of therapy they probably don’t need. This practice becomes more questionable when the therapists available to offer this therapy just so happen to be graduates of that very course. Can providers of training really do no better on the personal development front than to mandate personal therapy?

One size fits all
One of the many roles I have found as a counsellor and psychologist is to help clients reduce the rigidity of their thinking; to show them that their way of thinking can be detrimental to the way they are feeling and behaving. But as counsellors ourselves we seem to be the most rigid in our thinking. Fully aware that there are other methodologies of counselling, we seem determined to stick up for our model regardless of the evidence saying other methods are as effective.

How can this ‘one size fits all’ therapy help the client? If a particular client doesn’t fit the way we work, we try to change the client to fit our methodologies. Would it not be more beneficial to the client if the counsellor had more than one way to engage with a client to facilitate the change the client is so desperately looking for?

If we only have one way of working, we become more like the GP the client has tried so hard to get away from with their offer of anti-depressants and sleeping pills. I know all too well that CBT is not the answer just as we know anti-depressants are not the only answer. But person-centred, humanistic, solution focussed, gestalt, narrative, psychodynamic... not one of these offers the answer either. Counselling and psychotherapy in the UK seem different to most professions – usually you’re trained to offer a general level of skills and then after a while you specialise. With us it seems reversed – we pick the model that fits best with our way of thinking, specialise and then some of us work to increase our skills base.

What attracted me to the USA course was that it was the opposite – market forces in the USA mean counsellors need to have an array of base skills and then specialise when they have achieved these.

Bridging the gap
While we decide amongst ourselves who is better to serve the psychological needs of the great British public, there remain an ever-increasing number of individuals desperate for talking therapy. What can we do to bridge the gap between the many people seeking and needing some form of psychological therapy with the many practitioners waiting for the phone to ring with their next new client? The Increasing Access to Psychological Therapies initiative (IAPT) is doing something to bridge this gap, but I’d like to encourage the Government to go one step further. And surprisingly, this may not cost them any more money.

Back in the USA, I was unfortunate enough to damage my knee. After going through the mandatory stage of taking medication I returned to my doctor and was given a prescription for physiotherapy, three times a week for six weeks. With this prescription it was up to me to choose from a network of physiotherapists and take this prescription to them. They would then cash the prescription in for their hard-earned dollars.

So what has my knee injury got to do with therapy in the UK? Imagine a system in the UK where someone in need of psychological therapy goes to their GP and is given a prescription for six sessions. With this they can choose from a network of approved counsellors and therapists. Each therapist will then get a
set amount per session from his or her local NHS trust. If the client picks a therapist who charges more than the reimbursement value from the NHS, the client would pay the difference. After the six sessions, if the therapist thought they needed more sessions, they could write to the GP for authorisation for another six.

This model empowers the client – no longer are they a passive participant in their therapy but are actively encouraged to seek out a therapist they feel can meet their needs the most. Statutory services meet private practice, removing waiting lists but more importantly removing dependency to the client on an ‘expert’ to tell them the type of therapy they need.

Opening ourselves up
It’s important to remember that there is no one way that works as a counsellor, nor is there one model or one way to train and gain personal insight. I know that the way I work seems to be successful, but I am open to learn about others’ experience of working with individuals, and open to integrate the parts I find remarkable about the way they work into my own practice. The case studies presented by Annie Reed Henderson allow us to gain valuable insight into another counsellor’s good practice. For me, facilitating a group with two other practitioners from very different theoretical viewpoints to my own is an equally insightful experience.

Articles such as Clive Carswell’s and Jim Wilson’s inspire me to think differently about the individuals I work with. Although focusing on children and family therapy, Wilson’s insights should resonate throughout our work with any clients. The therapist who does not experiment or enter his discomfort zone is not likely to find new methods or skills in working with children. And something we should all remember when evaluating the theories that ground our practice: ‘It is not the therapist’s theory that connects with the child – it is the therapist’s humanity.’ These are the types of articles that move our profession forward and push the boundaries of our thinking.

I was trained that the client is always at the forefront in all that you do as a counsellor. I am fortunate to be allowed entry into an individual’s intimate thoughts and feelings, party to some of the most personal details about an individual’s life, and see people who at times are in the depths of despair. If a client has the courage to open him or herself up to us, surely we must have the courage to open ourselves up to the vast array of counselling methodologies and theories. The bickering amongst us must stop.

Simon Proudlock is a counsellor and psychologist working in private practice and for the NHS. He is also chairman of the Reading-based charity No5 Youth Counselling.

References

Time for a sea change?

I have to say ‘three cheers and then some’ in response to the letters by Nick Totton, William Johnston and Paul McGahey in the March edition of therapy today. Paul’s letter in particular rang such bells for me. I am, as he suggests might be the case for many of us within the BACP membership, one of those who is indeed feeling ‘excluded, disheartened, disenfranchised’ and, yes, angry at the direction counselling as a profession seems to be going in – to the point where I have begun to think ‘well, if that’s what a counsellor is, I’m not one,’ despite my senior accredited standing.

I’ve even started wondering if it’s time to coin another word for what we do: those of us engaged in and committed to relational work, and to all the exploration possible through sensing, intuition, being, creativity and thinking outside the box, as the territory of ‘counsellor’ seems to be increasingly devoted to the notion that what we do, or should be doing, is applying techniques in order to ‘fix’ clients.

One of my points of greatest alienation was reading the ENTO Counselling Standards, which came across to me as based around counsellors’ ability to ‘diagnose and treat’. I don’t do diagnosis, I am not interested in diagnosis and I don’t have any wish to treat (in the medical sense) anyone. It’s not a question of whether I can do any of that, or can find ways of describing what I do in those terms; I’m not prepared to validate that kind of thinking by engaging with it. And this seems to me to be where the greatest difficulty lies.

People who are not counsellors are setting an agenda for counselling and counsellors, and we, collectively, are allowing them to dictate the terms in which the debate (about what counselling is and should) takes place. And that needs to stop, now. Why do those of us engaged in relational work (etc.) allow ourselves to be pushed into defining what we do within the frame of reference of a medical thinking, which, in my experience, does not on the whole serve the needs of people with mental health issues? And for the record, in case this leads anyone to think that I don’t deal with the real world, I manage a counselling service for young people, funded and managed through the local youth service, and have done for the last 16 years or so.

A significant number of the BACP membership are, I believe, person-centred counsellors. Do those people (and/or others) feel represented by all the endless space given to Lord Layard’s proposals and...
Letters

Erratum

We would like to apologise to Matt Fossey for incorrectly attributing to him a letter about the IAPT programme in our March 2008 issue, page eight. The letter was in fact from Sally Aldridge, BACP’s Head of Regulatory Policy.

Contact us

We welcome your letters. Letters not published in therapy today may be published online at www.therapytoday.net subject to editorial discretion.

Email your letter to: therapytoday@bacp.co.uk or post it to:
The Editor, therapy today, BACP House, St. John’s Business Park, Lutterworth, Leicestershire, LE17 4HB.

Whatever happened to our core conditions?

As I read the articles on IAPT as well as several letters relating to the growth of CBT in the March issue of therapy today, I smiled as it dawned on me that counsellors are human too. The articles and letters reflected to me the expression of the ancient human trait of ‘territorialism’. I wondered if the traits that the authors seem to be trying to protect would not make them more accepting of theoretical and practice differences within our profession. It seems that the fear of being overrun by CBT somehow threatens to minimise the long-held traditions of counselling such as acceptance, unconditional positive regard and respect etc. When under threat we humans draw lines and battle plans, gird our loins and prepare for battle. It becomes them and us and our core

CBT – righting some wrongs

I am writing in response to the interview with Darian Leader in last month’s issue (therapy today, March 2008). As a counsellor and clinical psychologist I have followed the debates around CBT with interest. I feel they have been fairly balanced, although I must admit that David Veale’s recent article (‘Psychotherapy in dissent’, February 2008) read more like something in a physics book than a counselling journal.

However, I was both disappointed and angered by the ill-informed comments made by Mr Leader regarding CBT. He states ‘the treatment was originally designed using animal experimentation to modify behaviour’. This is simply incorrect. CBT in its current form arose primarily from the work of Aaron Beck, (and to some extent Albert Ellis), both former analysts. Beck had noticed in his years of work with depressed people the prevalence and centrality (in his mind) of negative thinking, and this became his focus. This has nothing to do with the modification of animal behaviour. Perhaps Mr Leader is thinking of older behaviour therapy work on phobias, or behavioural modification programmes for challenging behaviour, which did draw on conditioning ideas from animal research. This is not CBT as applied to anxiety and depression, or for that matter psychosis and personality disorders.

He then goes on to say ‘it’s well known... that CBT was widely used in China in the Cultural Revolution’. Well-known by whom? Beck’s CBT emerged at the end of the 1970s, as this period of societal madness was drawing to an end in China. Whilst abusive practices were rampant in seeking to change people’s thinking in the Cultural Revolution, to call these CBT is both incorrect and inflammatory. I am also tempted to raise the issue of people in glasshouses – anyone who has read Mason’s Against Therapy, or knows of psychoanalysis’s former approach to what it called the ‘perversion’ of homosexuality, will be aware it has its own chequered past. Yet to blame a set of ideas for the misuse society or individuals have made of them is hardly fair.

I would have liked to see the interviewer challenge such misinformation. It really does not help a balanced debate on the pros and cons of different therapeutic approaches.

Dr Sam Stephens

Liz Harris

Related issues within therapy today, a further example of which is printed in the March issue? Nick’s letter (amongst others I’ve seen) is a clear indication that there is nothing cut and dried about the pre-eminence of CBT. Is anyone else out there as frustrated as I am? Maybe it’s time for a sea change here.
I read Helen Coles' article ('Personal development criteria') in the February issue of therapy today with some recognition and resignation. The article states that personal therapy is not the only route to self-awareness. I agree with the author's premise that personal therapy is not always successful: how could it be? But is this a reason to give up personal therapy as compulsory criteria? If accredited counsellors are going to take clients through a counselling contract, surely it is essential for them to have experience of a counselling contract themselves. Much emphasis is given to the psychoanalytic approach and the unconscious processes when trying to describe processes that we are unaware of. This is a pity as in my view it is central to all counselling approaches. One of the effects of not requiring compulsory therapy that is not mentioned in the article is a lower standard of trainee counsellor. One of my roles is as a manager of a counselling service in the voluntary sector. I spend a lot of time screening out trainee counsellors applying for placements. We ask for personal therapy experience and maturity. As Helen Coles points out, therapy experience is not a guarantee of self-awareness, but it's a start. The trainees who succeed in getting placements are without exception people who have had successful therapy and the self-awareness that comes with that. They take therapy not as part of course criteria but as benefiting themselves, independent of the placement.

I am at an advantage because I have the experience and resources to screen potential counsellors, which the private client doesn't have. Perhaps there ought to be criteria for successful therapy? But then what is successful therapy? All I can say is, I know it when I see it!

Adrian Scott
BA Hons, MBACP (Accred)
Trainer/Lecturer/Group Facilitator

As Sarah Browne says, 'getting the Government to put £170 million into psychological therapies is an incredible achievement,' (therapy today, March 2008) and indeed this is so. From the experience of colleagues who are therapists and supervisors and my own experience as a practitioner of nearly 20 years, it is abundantly clear that there are already thousands of trained and qualified therapists who cannot find enough paid work or any work at all. These are people who have paid for their training themselves.

We are all aware that money is scarce, so why is there such a huge movement to provide funds to train thousands of new practitioners when there are thousands already trained and qualified? If the outcomes of therapy need to be measured and evaluated (and I agree this is financially a must, and ethically right and necessary), why is the Government not proposing to make use of the resources – i.e. the already trained and qualified therapists – that already exist? Surely this would be much cheaper than starting from scratch?

My questions are: 1. Is there going to be a system implemented to provide more jobs for already trained and qualified practitioners? 2. Is training to be implemented and provided to existing trained and qualified therapists to enable them to evaluate and measure their work according to NICE guidelines? Why do we not measure and evaluate our existing resources before spending money on what we may not need?

Susan Eccles
MBACP (Snr Accred) Counsellor, Supervisor
UKCP Registered Psychotherapist

[Editor's note: As Lord Layard stated in therapy today, March 2008, those running the IAPT scheme want to encourage trained and experienced practitioners to apply for jobs in the programme and those appointed to high intensity roles will be trained in evaluation].
Stifling debate not encouraging it

After reading the article by Helen Coles in the February edition of therapy today, I feel very disappointed that she was not able to find a level and to say that there is no evidence that this would be reduced by a stipulation for personal therapy to be included in training. It seemed as if his view was quoted because it fitted with BACP policy, not because it was a well-established fact.

I am not alone in finding a level of 31 per cent of complaints against accredited members very high and to say that there is no evidence that this would be reduced by a stipulation for personal therapy is puzzling, as presumably there is no evidence that it wouldn’t be reduced either. How come this is not being researched? Surely there is a need for good quality research into the usefulness of personal therapy before a decision can be reached.

At the end of the article Ms Coles quotes from a letter written to therapy today by Dave Mearns, presumably as a way of backing up the argument against personal therapy. As far as I can see, he was only offering his personal opinion and there are many experienced and well-known counsellors and psychotherapists who would argue the case for personal therapy to be included in training. It seemed as if his view was quoted because it fitted with BACP policy, not because it was a well-established fact.

I am still not clear why BACP originally reversed its decision on personal therapy and on what grounds that decision was taken. I am sure I am not alone in finding a level of 31 per cent of complaints against accredited members very high and to say that there is no evidence that this would be reduced by a stipulation for personal therapy is puzzling, as presumably there is no evidence that it wouldn’t be reduced either. How come this is not being researched? Surely there is a need for good quality research into the usefulness of personal therapy before a decision can be reached.

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Psychotherapy is my profession; I care deeply about it and how the general public sees it. I do not understand how BACP can stand as an organisation whose purpose is to encourage and promote counselling and psychotherapy and yet imply it’s not necessary for its members.

Marji Coulson
MBACP UKCP Registered Psychotherapist

Words and labels

I take note of Ian Plágaro-Neill’s comment upon my use of the word ‘schizophrenic’ in my article in February’s therapy today. I do not wholly disagree with the point he makes. Thus, phrases such as ‘people with learning disabilities’ seem respectful, and that is good. However, in very complex situations I doubt that we can reach a satisfactory position through linguistic adjustment. The case of schizophrenia is fascinating and difficult. I am yet to come up with a turn of phrase that I am happy with.

The virtue of the word schizophrenic is that it is a label that is both imprecise and yet meaningful. It is also highly political. It is not a case of putting, in Ian’s words, ‘the condition before the person’. It is a question of trying to find a way of expressing how difficult it is to generalise about the experiences of people with mental health conditions. I reject the idea that a particular usage marks a ‘bad’ attitude and another to a good one.

For me the term ‘schizophrenic’ marks out a group of people who are so labelled. This is just where Ian is right. That is what they have in common. Let us think what the alternative might be. ‘People diagnosed with schizophrenia’ although cumbersome, looks more correct, but actually points to the diagnosis, and not the range of conditions. ‘People with schizophrenia’ I reject on the grounds that it gives pseudo-medical validity to the term schizophrenia. I await a useful suggestion, but I fancy that there are no neat verbal usages, because there is no neat reality.

Above all, I want to hold in question the notion that there is a disease called schizophrenia. The terminology must grate on us. The reason that schizophrenics are not a homogenous group is not about seeing the illness rather than the person. It is that the label schizophrenic designates a group of people who have diverse ways of processing experience, who often receive a medical diagnosis, but one that is open to severe questioning because it is neither reliable nor valid, in the technical sense of these words.

Richard Worsley

Chinese herbs – not a distraction

I was astounded to read in Annie Reed Henderson’s article ‘Unexplained Fertility’ (therapy today, February 2008) that ‘couples tend to conceive when they are not focused on having a baby. For example, conceptions during the adoption process or while using Chinese herbs are examples of distractions that result in an increased chance of conception...’

Whilst I wouldn’t argue with her premise that couples often conceive whilst less focused on the aim of conception, I was appalled that she could dismiss Chinese herbal medicine as merely a ‘distraction’. In my experience as both an acupuncturist and counsellor, I have often referred couples struggling with infertility to Chinese herbal medicine practitioners as an adjunct to acupuncture or counselling, precisely because it is so successful at enabling fertility and increasing the possibilities of conception.

Debbie Collins Lic Ac, MBAcC BSc (Hons), MBACP (Accred)
Economic and moral double standards

In his letter ‘Need to measure value’ (therapy today, March 2008), Gavin Robinson comments, reasonably enough, that we live in a world ‘measured by money’ and asks whether we might have to ‘work with the reality and not an idealised world?’ I appreciate that he is trying to be pragmatic, and it’s an argument that might be compelling were it not for the fact that reality is not necessarily quite what it seems. Money is the supposed measure, but if the NHS really were run on purely economic lines, then it would look very different. Economics certainly cannot justify medical or surgical procedures carried out on anyone over the age of 60. Far better to let them die and avoid both the cost of the operation as well as the subsequent care costs, including state pensions. In fact, the health of the nation – and its economy – might be far better served by closing down hospitals and devoting the resources to basic community healthcare, and the promotion of healthy living. Could it be that technology makes medical spending so attractive? There seems to be a parallel with spending on armaments. Technology, whether it preserves life or destroys it, is neat, seductive and easily quantifiable. Living is much messier and harder to define. Is economic prosperity more important than human happiness? Is prolonging life (or ending it) more important than valuing it? These are economic and moral double standards that need to be confronted. As things stand today, physical existence must apparently be saved – or destroyed – at any price, but the things that make life worth living carry a price tag. If we believe that it’s worth spending money to try and save the life of a cancer patient with no economic prospects, and no guarantee that a prolonged life will bring happiness, then I cannot see why we should not spend similar sums on helping someone towards spiritual, emotional and human fulfilment. If we believe that economics should not be the principle measure of what is important, then it seems to me doubly vital that we do not become apologists for those who both demand that we prove our economic worth, whilst ignoring economic considerations when it suits them. William Johnston

Mary Swainson 1908-2008

Dr Mary Swainson, pioneer student counsellor, died on 23 March 2008, on her 100th birthday. She came from a clergy family in the West Country, and enrolled for an external honours degree in geography at Exeter University College in 1927. As a lecturer in geography, she became increasingly interested in educational psychology, and gained a DPhil at Oxford in 1939.

She returned to Exeter, where she met JW Tibble and shared his vision for teacher education and her for a service to respond to students’ emotional needs. Two years after he became Professor of Education at University College, Leicester, Mary joined him in 1948 as Lecturer in Education and Geography, with the unwritten understanding that she would begin to offer counselling to education students. She wrote, ‘I should be pioneering in something I had not been appointed to do’ – words which will resonate with those who like myself were creating counselling services for students in the early 1970s.

Mary gently and quietly offered counselling to undergraduates at Leicester University, then the College of Education at Scraptoft and Leicester Polytechnic, while continuing her lecturing role. This much-used counselling service was never formally acknowledged; she was never given an office on campus, and saw students in her own home. Then in 1967 Dr Hugh Binnie, Chief Medical Officer of Leicester University Student Health Service, invited her to become part of their team, which included a psychiatrist and medical and nursing staff.

Mary retired from the role of university counsellor in 1972, a few months after I had been appointed to develop student counselling at Leicester Polytechnic, and she agreed to become my therapist for a few months until she moved away. But she never did move, and I saw her weekly for the next six years, as I too struggled with a pioneering role. I owe her a great debt as she enabled me to discover my own creativity, and the courage to innovate. She was an extraordinary woman who wrote and published books about spiritual healing after her retirement and whose last Christmas letter to me asked me to reassure any of my elderly friends that there was nothing to fear about going into a nursing home, provided they had done their research and found a good and caring one as she had done.

She faced her aging and her dying gracefully, and efficiently, ensuring that all her friends would receive the news of her death from the solicitors who were also her executors, and who clearly cared deeply for her. I am thankful to have known her.

Jean Clark
Fellow BACP