Differing approaches to training and practice in counselling

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To set the scene, I give a quotation and a story:

> I came to therapy hoping to receive some butter for my bread. Instead, I received sour milk, a churn, and instructions on how to use them[1].

A good GP practice in the inner city, recognizing that the needs of many of their patients, particularly the 'heart-sink' patients, were primarily psycho-social rather than medical, resolved to employ counsellors using FHSA funds and some of their own resources.

However, it transpired that it was taking the counsellors a very long time before they could help these patients, and when and if they did, the effects seemed modest. After attending an event on 'Evaluation in counselling', at least one of the GPs was left with the feeling that in setting out to bring about a change for their patients, they had ended up realizing that counsellors also found these patients difficult to help. Furthermore, the GPs were having to re-construct how they viewed their entire practice and having put their hands in their pockets, ended up realizing that they were the ones who would have to change.

The British Association for Counselling (BAC) defines counselling as follows:

> People become engaged in counselling when a person, occupying regularly or temporarily the role of counsellor, offers and agrees explicitly to give time, attention and respect to another person or persons, who will temporarily be in the role of client. The task of counselling is to give the client an opportunity to explore, discover and clarify ways of living more resourcefully and towards greater well-being.

Such definitions and various elaborations of them, have begun to assume much wider importance in recent years for a number of reasons. At present, counselling and psychotherapy are unregulated activities; anyone may call themselves either a counsellor or psychotherapist and they may have had either intensive and extensive training, or none at all.

The practice of counselling skills is even more variable, except when called counselling or psychotherapy, their practice may be inexplicit - the 'client' (or rather the 'patient', since the role of the recipient of what is offered in the NHS will be primarily in receipt of health services) will probably be aware that they are party to an interaction qualitatively different to the provision of information or prescriptive instructions, but may not recognize the specific skill of the 'carer'.

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This leads to a distinction between counselling skills and counselling, one of a number of considerations that make definition more important. Much work that involves counselling skills would not fall within the BAC definition of counselling given above because there is no sense of an explicit contract that defines the task as counselling. Furthermore, even where NHS workers have job titles which include counselling, they may well not be eligible for BAC Accreditation as a counsellor because of difficulties with at least one of the following criteria:

(i) they may not have participated in personal development activities and relevant training;
(ii) they may lack the experience of being a client;
(iii) they may not have received appropriate supervision.

Therefore, although the use of high level communication, interpersonal and social skills with the philosophical underpinning of the counselling ethic is clearly related to counselling, it is not the same thing. One of the participants in the differentiation project is reported as offering the analogy that although 'changing the spark-plugs on a car may require mechanical skills, it does not make you a mechanic'[2].

The distinction between counselling and psychotherapy is more complex. Both are umbrella terms for sets of activities. Some conclude that there are no essential differences and use the terms interchangeably[3]. Against this, there are possible distinctions based more on emphasis than discrete differences, that counselling is client-centred rather than therapist-centred, emphasizes the relationship rather than specific techniques, is based more on humanistic rather than psychoanalytic or behavioural theory, and takes place in non-medical rather than medical settings. Nelson-Jones argues that both counselling and psychotherapy are based ideally on the 'informed and planful application of techniques derived from established psychological principles' and this is a widely-used research definition of the 'psychological therapies'[4,5]. I am personally aware of a pragmatic distinction when clients present because of a particular acute traumatic event for them, their child, partner or other close relation (e.g. major illness or disability, a major disaster or a more personal accident or incident, such as an assault or rape, a loss or bereavement), that in the first instance, it has become common for such people to be offered or encouraged to seek counselling, but that they would probably be traumatised further by the suggestion of referral for psychotherapy. Psychotherapy on the other hand would probably more likely be considered in the situation of a more chronic pattern of difficulty giving rise to dissatisfaction, independent of any particular event.

In considering the range and extent of current practice of counselling in the NHS, it is notoriously difficult to obtain accurate data and I am grateful to Graham Curtis-Jenkins, Director of the Counselling in Primary Care Trust for his latest estimates: there are approximately 8200 BAC members overall, although by no means all of these will be practising, and if they are, then it may not be to any great extent. The number of counsellors in primary care is estimated at between 500 and 1000, and the number of practitioners of related disciplines such as nurse therapists, engaging in counselling or practising

counselling skills in the NHS, is around a further 1000. Counsellors in private practice, with estimates based on entries in the BAC Counselling and Psychotherapy Resources Directory and the trained membership of organizations such as Relate, the Westminster Pastoral Foundation and the Mental Welfare Association add a further 3000 to 4000.

Criticisms of the BAC Accreditation and Recognition schemes and the Divisional schemes are numerous[6]. One apparent weakness is the seeming reliance on time limits alone (e.g. 450 h supervised practice over 3 years; a minimum of 1½ h of supervision per month, etc.), with no explicit reference to the outcomes of counselling. Inevitably, in any field there are accredited practitioners that one would avoid personally as well as types of approved training capable of turning out incompetent practitioners. What is interesting about BAC Accreditation is that it is limited to 5 years and demands a career-long commitment to continued supervision, personal and professional development, and adherence to the fairly searching BAC Code of Ethics and Practice; this potentially distinguishes counselling as a highly reflexive field of practice. It is, in my view, the emphasis in counselling on standards of reflexivity that distinguish it from related fields such as psychiatry and applied psychology which depend far more on the concept of expertise as a sufficient safeguard for clients.

One of the challenges of the value of counselling for the NHS is that we are all potential helpers and clients. This has been highlighted by the experience of dealing with major disasters, such as the Bradford fire and the capsize of the *Herald of Free Enterprise*. These experiences, beyond the range of what most people had previously encountered, extend the notion of victim well into the population of rescuers and helpers.

There is now widespread recognition in responsible quarters that medicine has a vital but limited contribution to make to health. Counselling is a 'buzzword' in health care but there is a danger (illustrated by the quote and story at the beginning of my talk) in the face of pressures to answer questions like 'Is primary care/hospital medicine effective?' and in response to the direction of unhappiness and distress to the NHS at many levels, in the search for allied skills that may seem to help in providing a more positive answer than the traditional medical approaches of diagnosis and prescription. That is, that if truly taken seriously, the values of counselling and counselling psychology may pose such a serious challenge to the philosophical basis of traditional medical practice, that either they can only be genuinely incorporated at the expense of a fundamental change in the way health care is delivered or that true counselling can only take place in the context of an independent and separate profession.

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The need for counselling skills in general practice

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Introduction

Epidemiological studies in Great Britain and the United States, suggest that the rate of mental illness in the population is in the range 10%-15% at any point in time. Of these, non-psychotic disorders, anxiety and depression are the most prevalent. In the United Kingdom, the main point of contact for people with psychiatric disorders is not psychiatric services or community psychiatric teams but the General Practitioner. Double the number of contacts occur for psychiatric disorder in primary care compared to other forms of psychiatric contact[1]. National Morbidity Statistics show that psychiatric disorders rank as the third most common cause of consultation in primary care (9%) following causes related to the respiratory (15%) and the cardiovascular (11%) systems. In addition, if we consider the role of other members of the primary care team such as practice nurses, health visitors or community nurses, the figure for consultations occurring in primary care would be much higher than that of GP consultations alone.

Costs

A recent study has measured the economic effect of these disorders and this evidence alone suggests the need to take these problems seriously[2]. Table 1 shows the economic costs of the non-psychotic disorders and includes the costs of treatment which are small in comparison with the costs of sickness absence and early retirement.

Severity and chronicity

It is also important to ascertain the severity and duration of the problems treated in primary care.

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