THE HANDBOOK OF
COUNSELLING PSYCHOLOGY

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COUNSELLING PSYCHOLOGY

Edited by

BARBARA DOUGLAS, RAY WOOLFE, SHEELAGH STRAWBRIDGE, ELAINE KASKET AND VICTORIA GALBRAITH

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SECTION I

SITUATING COUNSELLING PSYCHOLOGY

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Have you ever looked for a map online only to discover that what comes up is a detailed localised map of the area highlighting the feature you are after (e.g. a hotel)? I did this recently, looking for a country house hotel, and discovered that while I found the hotel I still had little idea where it was. There were few broader clues to help me locate the hotel in its wider context. Just as we need these clues for geographical understanding, so we also need them to locate ourselves, both personally and professionally, in context. We, and our clients, are all relational beings living in social, historical and cultural contexts which become integral to us, and with which we interact daily.

Our profession – counselling psychology – also exists in relation to, and situated within, the wider contexts with which it interacts. Through this interaction, both the profession and its wider contexts are influenced and changed. This first section of the *Handbook* looks at exactly this. Chapter 1, 'Mapping the world of helping', begins by situating counselling psychology in the world of helping, asking that most fundamental question which can sometimes be overlooked: What is helping? It then considers the nature(s) of professional helping and the languages of helping which act to determine, or influence, how we perceive the values, process and practice of helping. It reviews, for example, the notions of reflective practitioner and scientist practitioner and whether a medical model is an appropriate one in which counselling psychology should sit. It concludes by emphasising the dialectical nature of these processes and how their constantly changing interactions result in mutual influence on both counselling psychology and its related professions.

Chapter 2, 'Science, craft and professional values', follows with a detailed consideration of aspects of the scientific contexts in which counselling psychology is located. We may talk about the scientist practitioner, for example, but what science is, and is not, as well as its socio-historical development, are things that we may overlook, yet they underpin any critical examination of research. Similarly, we may overlook the socio-cultural evolution of a more specific psychological science, its theories and models, and how these have interacted (and continue to interact) with the profession of counselling psychology. The chapter demonstrates a tension between the natural and human sciences in which we sit and discusses how we recognise, give weight to and value knowledge that may be less amenable to some definitions of science; that is the tacit dimension of 'knowing how' rather than 'knowing that'.

The themes put forward in these important first two chapters provide much food for thought. In setting the scene for much of what is contained within the following sections and chapters, they set a course for an evolving internal map of the field of counselling psychology for the reader.

1

MAPPING THE WORLD OF HELPING: THE PLACE OF COUNSELLING PSYCHOLOGY

RAY WOOLFE

INTRODUCTION

The aim of this chapter is to locate counselling psychology within the world of helping. Using the metaphor of this world as a map, where is counselling psychology to be found? The task involves exploring what the world of helping consists of but also in unpicking what we mean when we refer to counselling psychology. Is it a body of knowledge or a discrete discipline or a philosophical approach or a form of practice or, in the final resort, no more than the title of a division within the British Psychological Society (BPS)? These are all variables that enter into the mapping process and the outcome unsurprisingly is not simple or two-dimensional.

What then does it mean to call oneself a counselling psychologist? Individuals enter programmes of training in the subject for a variety of reasons and with a variety of already established personal and professional identities. While it potentially represents a vocational qualification, there may be a greater or lesser commitment, at least initially, to its ethos and philosophy. Even people who complete training may have a less than clear understanding of what their qualification in counselling psychology means or stands for in terms of offering a professional identity or how it differs, if at all, from the identity offered by other programmes of training, such as clinical psychology on the one hand or counselling/psychotherapy on the other. If, in the end, people from a variety of different trainings find themselves working in the same NHS or IAPT settings, for example, and doing the same work, is it logical to assume that their different titles are different in name only?

Perhaps it was easier to differentiate counselling psychology from other therapeutic enterprises in the early days of the discipline. Before the division was established within BPS I described counselling psychology in Britain as 'an idea whose time has come' (Woolfe, 1990). The philosophy and approach to helping seemed to offer a scientific basis to counselling and at the same time a more intuitive, artistic and humanistic basis to psychology than provided by

clinical psychology. The ethos and philosophy of humanistic psychology, of an empathic engagement with the client, the importance of the helping relationship and a concern with health rather than pathology seemed to set it apart. But a quarter of a century later, this outlook has collided with the *Zeitgeist* of a less idealistic world focused on performance and outputs. If one works in an organisation such as the NHS, or indeed any organisation, one cannot but be influenced by the culture of that organisation. Cultures are dynamic and subject to change, and a focus on evidence-based practice has become the central theme of helping, certainly within the NHS. I have argued (Woolfe, 2012) that central to the success of counselling psychology up to the present time has been the ability to identify a narrative around which all counselling psychologists, whatever their preferred orientations, could rally. This offered an identity and a statement of difference from other helping practices. It provided a scientific base but at the same time paid allegiance to the relationship between client and therapist. This narrative is of the reflective practitioner and there is a question of whether it can survive in a world of evidenced-based practice. At the same time counselling psychology did not invent this idea, has no copyright on it and it is well represented in other professions. I intend to examine the concept more closely but first I want to step back and think about what is involved in helping.

WHAT DO WE MEAN BY HELPING?

The world of therapy is a coat of many colours (Woolfe, 2011) and consists of a large number of occupational groups with a vast variety of titles. These include counsellors, psychotherapists, psychiatrists, drama therapists, group analysts, clinical psychologists, family therapists, hypnotherapists, occupational therapists, mental health social workers, community psychiatric nurses, and so on. One could go on and on; this list is by no means exhaustive. Were we to engage in an imaginary exercise of constructing the world of therapy from scratch it might look a lot simpler than the patchwork quilt that presently exists. As it is, the boundaries between different categories of therapy are frequently opaque. The few clear ones include psychiatry, for which one has to be a medical practitioner, and counselling psychology and clinical psychology, respectively, which necessitate a psychological qualification. As for counselling and psychotherapy, this is a minefield of complexity. The difference between these two activities, if it exists at all, is not clear. For many years the British Association for Counselling (BAC) resisted including psychotherapy in its title but eventually changed its mind and is now the British Association for Counselling and Psychotherapy (BACP). The reasons are complex but owe as much to politics as to rational debate. Dryden (1996), in discussing this difference, refers to it as 'a rose by any other name' (p. 26) and ends the article in light-hearted fashion by describing the difference between the two as 'about £8000 per annum' (p. 27). Readers interested in a less witty but more detailed exploration of differences between the two concepts will find this in Woolfe (2011, p. 20).

    The word 'therapy' is often employed as a commonality binding all these categories together. But of course not all helpers could be accurately described as therapists. For example,

someone who works in an advice bureau or human resources department or indeed in any caring capacity would seem to have just as much right to be described as a helper as someone who describes themselves as a therapist. Samaritans are clearly helpers but elect not to describe themselves as therapists. Many counselling psychologists work in sectors such as work or education and their role is not defined as a therapist and many would not think of themselves as therapists. Does this then set them outside the world of helping?

It is instructive to reflect on what is implied by the term 'helping'. If one helps a child to cross the road, one would appear to be performing the role of helper, if only very temporarily. However, this seems to set the definition of helping so wide as to make it almost meaningless. What of the paid carer who looks after a group of people with severe learning disabilities or older adults? Such a person might not be trained as a therapist but might well have training and expertise in key aspects of therapy, such as listening skills or non-verbal communication. Perhaps, then, when we talk about the world of helping we are referring to paid professional roles. But if we do this, we exclude the volunteer counsellor or advice worker. Therefore, a definition of helping and, by implication, the world of helping seems less clear than would at first appear to be the case. It includes professionals and volunteers with therapists as just a sub-set.

WHAT IS A PROFESSIONAL?

For the purposes of this book we need to focus on the professional helper, which raises its own set of questions, most notably what does it mean to be a professional? Does the meaning differ across occupations? At its most basic, professionals profess, but what is it that they profess to? The usual definition is that it is based upon the claim of technical expertise embedded in a body of knowledge. Thus priests are seen to have specialised access to knowledge about the soul, doctors to the body and psychologists to the mind. Professionals have traditionally grouped together in associations, in theory to develop their expertise, but in practice serving to establish firm boundaries to exclude others. Historically, the state has mandated their privileges by allowing them the right to define entry standards and to manage their own affairs. In recent times the state has sought to intervene more actively in the work of professional bodies and to give greater rights to consumers of services.

However, to emphasise technical expertise takes no account of the intersubjective frame in which this expertise is encapsulated. This consists most crucially of a relationship in which one person has a set of needs and the other professes to have the ability to respond to these needs. Thus there is a power imbalance. While some counselling psychology practitioners may emphasise the need for equality between client and practitioner, the reality of their respective positions is inescapable. The fact that one party is more powerful than the other leads to the potential for abuse, which in turn leads to a second characteristic of professional groups, which is a commitment to a set of principles and rules based upon altruism, caring and commitment. Arguably the most important chapter in this book is the one entitled 'Toward ethical maturity in counselling psychology' (Chapter 15). What we do in a relationship matters but this has to

be embedded in a particular disposition which all helping professionals are expected to bring to that relationship. While the world of helping is characterised by many different professional groups, what they all have in common is a concern with the ethical basis of their practice.

CODES OF ETHICS

The ethical basis is expressed in codes of ethics and practice drawn up by the respective professional bodies. Different professions have their own subtly different codes of ethics and practice but it is informative to examine those that exist within the professions of psychology, counselling and psychotherapy as they provide us with information about how professionals are expected to approach and attend to their responsibilities and overall duty of care towards their clients. Until relatively recent times, both the British Psychological Society (BPS) (1993) and the British Association for Counselling (BAC) (1993) had ethical codes that could be described as fairly prescriptive, laying down explicit rules about what was regarded as minimum appropriate behaviour. However, more recently these codes have been revised (BPS, 2006) so that they are best described as aspirational rather than prescriptive and guidelines rather than rules. There is an emphasis on ethical awareness and reflection on practice and a focus on thinking about the values underlying practice. 'Thinking about ethics should pervade all professional activity' (BPS, 2006, p. 7). The Division of Counselling Psychology (BPS, 2005, p. 1) built upon the earlier document by seeking to identify what psychologists are expected to do in pursuit not of minimum but of best standards. The document states that 'mention or lack of mention in the guidelines of a particular act or omission shall not be taken as conclusive on any question of professional conduct'. In other words, each individual is expected to be responsible for and to monitor their own ethical practice on an ongoing basis.

This position is presented cogently by Carroll and Shaw (2012), who use the notion of 'ethical maturity' in the helping professions. They argue that too often people are guided by regulations or specified codes laid down by others and thus external to them. Their suggestion is that ethics should be practised internally. Thus the codes represent just the first step on the road to ethical practice. You can read more about this in their chapter in this book (Chapter 15). A similar development of approach can be found in British Association for Counselling and Psychotherapy (BACP) (2013). This document states that 'reliance on principles alone may detract from the importance of the practitioner's personal qualities and their ethical significance in the counselling or therapeutic relationship' (p. 1). It is a moot point as to the extent to which different professions adhere to a more prescriptive or more aspirational code. However, it appears clear that the more a profession commits to the latter and emphasises individual responsibility the more important is the relationship between psychologist and client. Counselling psychology, with its emphasis on the reflective practitioner, seems well positioned in response to the direction in which these developments are moving.

DISCOURSES ABOUT HELPING

The roots of therapeutic practice are complex and differ from profession to profession. Douglas (2010) suggests that there are a variety of discourses that frame attempts to understand therapeutic relationships with people with mental health problems and that these include religious, moral, medical and psychological discourses. Douglas and James (2013) suggest that psychotherapy contains a number of narrative accounts or ideologies of what the practice involves. They suggest that psychological services are largely framed within two competing world views. One they describe as 'psychopathological' while the other they see as emphasising the intersubjective world of client and therapist and the joint construction of meaning. In the latter, consciousness and agency are emphasised. The authors see these two world views as existing in a state of tension.

In practice, the discourse that has historically been of most influence is the former, which has been powerfully taken up by the medical profession. However, this view of the world goes back a long way and has its origins in an interest in and attempt to examine, explore, investigate and explain the natural and physical world. Aristotle argued that nature is understandable, explainable and predictable, while in the sixteenth century, Leonardo da Vinci was able to produce explicit anatomical diagrams of the human body and a century later Newton demonstrated the existence of cause–effect relationships. This process of scientific discovery accelerated during the so-called Enlightenment of the eighteenth century and its dominance developed in the nineteenth century as more recent intellectual giants, such as Darwin and Freud, began to identify and to answer questions about where we sprang from as a species and what psychological processes are at work within us. In the field of human behaviour, discourses about behaviour based upon morality (badness) were replaced by explanations based upon experimentally based scientific knowledge. In particular, the causes and treatment of a variety of diseases were uncovered and what has become known as a natural science model became elevated to its contemporary status. Its underlying philosophy lay in positivism; in the belief that the only valid data were those that could be observed and measured.

THE IMPORTANCE OF LANGUAGE IN DEFINING REALITY

Of course the language we use defines the agenda of any discussion. To talk about formulation, for example, sets up a different agenda from the language of diagnosis. In a challenging and provocative article, Rizq (2013) suggests that the language we use dictates how we work with clients. She points to the overwhelming influence of the philosophy of evidence-based practice. The language it fosters emphasises 'checking, auditing, regulating, measuring, assessing, evaluating and governance' (2013, p. 23). It is required for managers to get funding for services, for academics to get research grants and, above all, to label clients in terms of interventions and outcomes. She suggests that it 'polices the legitimacy of knowledge' (p. 22) and compares it to

Orwellian Newspeak. She suggests that 'it dispenses with the idea of relationship by converting suffering into a satisfying consumer activity' (p. 22). She reserves particular criticism for the English IAPT scheme (Increasing Access to Psychological Treatment).

This point of view is uncomfortable but important to consider. It reminds us that all theories about therapeutic practice situate clients and the conception of their problems in normative discourses. Douglas and James (2013) refer to this model as 'psychopathological'. However, while the word 'psychopathological' can sound rather pejorative in its tone, it encompasses a variety of relatively objectivist practices familiar to counselling psychologists, and to dismiss it out of hand as a kind of metaphorical supping with the devil seems unnecessarily undermining. All helping relationships involve interaction between human beings and to be effective have to create a working alliance. A relatively directive and structured therapeutic method such as found in behavioural protocols still requires that the therapist must get to understand the client sufficiently well to know what he or she will find reinforcing. This demands an ability to be empathic and to enter into the subjective world of the other. This seems a *sine qua non* of any helping relationship. Cognitive behavioural therapy has always emphasised collaborative empiricism but increasingly has taken on board insights from attachment theory and transference (see Parpottas, 2012). On the other side of the coin, professionals could not communicate without some common language and to do this without categories or labels is impossible. We cannot simply refuse to talk about borderline personality disorder, for example, because we disagree about the nature of this condition or, indeed, whether it exists. Language inevitably codifies and while Rizq rightly alerts us to the manner in which some forms of language are more privileged than others and, therefore, become more dominant, thus pushing us into a debate about this, the fact is that we cannot have the debate without first having an agreed language to debate with (see Woolfe, 2013).

THE MEDICAL MODEL IN PRACTICE

In recent times, the concept of a medical model has become the standard terminology for describing this approach to addressing issues about mental and emotional well-being. The model provides the theoretical underpinning for the idea of the scientist practitioner. A central plank is the idea of disease, which of course implies that there exists some sort of norm with disease as a deviation from this. Recognition of the deviation arises through the presence of symptoms and treatment is directed at the reduction and ultimate removal of symptoms thus restoring the organism to its original homeostasis. The presence of symptoms is identified through a process of diagnosis. This model places a heavy emphasis on the expertise of the professional while the role of the patient (as he or she is traditionally described) tends to be passive. It ignores, or at the very least downplays, the responsibility of the client for his or her own well-being. It fails to acknowledge the client's internal subjective experiences and the importance of the relationship between helper and client in responding to the latter's areas of concern.

Applied to mental health, the application of the medical model can be seen to have serious weaknesses. Categories such as depression or anxiety or attention deficit disorder or schizophrenia are not discrete, well-bounded categories in the same way as a broken bone or measles might be identified and treated. Whether a person is labelled as schizophrenic or having a traumatic psychosis disorder, or whether a person is labelled as having a borderline personality disorder or complex PTSD, may depend as much on the helper's professional identity and preferred theoretical orientation or research interests as on anything else. They are not truths but the product of a form of contested discourse which privileges certain accounts of reality at the expense of others. But one way or another, this is what Sanders (2006) refers to as 'the medicalization of distress'. This thesis has been well documented by contemporary British writers (see Johnstone, 2000; Parker, 1999; Pilgrim, 1997; Smail, 1978). However, I wanted to refer here particularly to the seminal work of Thomas Szasz, who writes in his book *The Myth of Mental Illness* (1961, p. 14), 'the question What is mental illness? Is shown to be inextricably tied to the question, What do psychiatrists do?') Szasz is frequently dismissed as a product of the anti-psychiatry movement of the 1960s, but this would be to ignore his insights. More recently he wrote in a manner that would be easily recognised by counselling psychologists that 'only after we abandon the pretence that mind is brain and that mental disease is brain disease can we begin the honest study of human behaviour and the means people use to help themselves and others to cope with the demands of living' (Szasz, 2007, p. 149). It is true that present developments in neuro-psychology are providing us with an outpouring of new knowledge on the relationship between brain function and emotional states but this does not undermine Szasz's basic thesis that we must differentiate between mind and brain.

If one responds to the question 'what do psychiatrists do?' by answering that they largely dispense medication, one immediately begins to point to the vested interest of the drug companies to defining the existence of emotional distress as an illness and as a consequence encouraging the identification of more and more new categories of illness (see Healy, 2004; Johnstone, 2000). The *Diagnostic and Statistical Manual of Mental Disorders – V* (American Psychiatric Association, 2013) has recently replaced DSM-IV as the standard psychiatric diagnostic tool but its creation has generated an enormous amount of impassioned debate. Particular concern lies in its tendency to medicalise normal developmental events such as bereavement. By the definition of DSM-V, normal grieving is assumed to last for two weeks, after which the assumption is that the continued presence of sadness in the individual is indicative of depression and should be treated as such. More generally, psychiatry has been attacked on the basis that its diagnostic categories are based on symptom clusters, not on underlying biological causes. This discussion is taken up in the next chapter of this book. We might also note the lack of emphasis which psychiatry places upon cultural factors (see, for example, Suman, 2010).

The question of where counselling psychology stands in relation to diagnostic categories is taken up by Larsson et al. (2012). They reviewed the counselling psychology literature pertaining to diagnostic categories. They found that a majority of the sources examined 'positioned counselling psychology between two conflicting epistemological positions' (p. 55). One view consistent with the psychopathological model adopted an empirical stance that counselling psychology should engage with the medical model while retaining its critical perspective. The other emphasised the 'phenomenological experience of the client' not making normative

assumptions as characterised by the use of diagnoses. They conclude by asking whether counselling psychologists can retain the philosophical value of non-pathologising in an environment dominated by the medical model. This question is a very pertinent one. Counselling psychology exists, as do all other helping occupations, in a real, not a theoretical, world and is intimately entwined in a symbiotic relationship with this world. People's livelihoods are at stake. Does a clinician, for example, refuse to take on medico-legal work (which is reasonably well-remunerated) because this frequently demands making a psychiatric diagnosis for the benefit of the court? Counselling psychologists are not immunised against such dilemmas?

The British Psychological Society has been active in addressing these issues and concerns. A document (2011) looks at formulation-based alternatives to psychiatric diagnosis. The latter, it points out, is deeply embedded in NHS practice:

> Trusts are required to return mental health Minimum Data Sets based on psychiatric diagnoses. The IAPT initiative is based upon diagnostic criteria for depression and anxiety disorders. NICE recommendations and most outcome measures are diagnostically-based, and a diagnosable mental illness is a pre-requisite for access to mental health services. (Division of Clinical Psychology, 2011, p. 24)

The document points out that 'most evidence-based practice is based upon classification by psychiatric diagnosis despite the fact that these terms are not evidence-based themselves; that is they have poor reliability and validity'. More recently, the British Psychological Society has issued a 'Position Statement on Classification' (Division of Clinical Psychology, 2013) which advocates a radical paradigm shift on how we understand mental distress, moving away from a model based on the diagnosis of a disease.

While it is tempting to perceive diagnosis as bad in the sense that it stigmatises individuals, we should not ignore the benefits that it potentially confers, not least the relief felt by some individuals when they are able to put a name onto distressing felt experiences. As emphasised throughout this chapter, it is naïve to talk about counselling psychology and its relationship to diagnostic categories without taking account of the occupational context and the wider world of helping in which counselling psychologists work. The reality is that the NHS and other statutory agencies increasingly represent the main forms of employment for counselling psychologists. Working in this environment, ideological purity is a luxury that may not be affordable.

THE REFLECTIVE PRACTITIONER

The main weapon in the armoury of counselling psychology in responding to this dilemma is through a commitment and adherence to the narrative of the reflective practitioner. This emphasises the role of the counselling psychologist as a self-reflective practitioner with a commitment to personal development work. Such awareness extends not only to technical expertise but also to the ethical, social, political and cultural context of their work. This has helped to give

it a discrete and separate identity from clinical psychology. However, it is important in a different way. The basic problem in finding an identity for counselling psychology lies in the multiple forms of therapy practised by counselling psychologists. This is built into the regulations for training in which practitioners are required to be proficient in more than one orientation, frequently encapsulating radically different philosophies. This differs from training requirements in counselling and psychotherapy where a single-model approach is more often than not standard practice. Given this requirement, how can this produce any form of unity or sense of a unified discipline? Put in another way, how can these diverse sources be integrated?

The diversity of practice can be demonstrated in an imaginative fashion through exploring ideas derived from literary criticism (see Frye, 1965), particularly in relation to the work of Shakespeare. Fear and Woolfe (1996, 1999) identify four visions of reality or outlook on the world, namely romantic, tragic, comic and ironic. These can be linked to different therapeutic methods. The romantic vision is that of the humanistic practitioner. Human beings are perceived as basically good and filled with potential, the life drama being of an exciting heroic adventure based upon an optimist stance. The role of the therapist is to facilitate this move towards self-actualisation or, to paraphrase Carl Rogers, to become what one is capable of becoming. In contrast, the tragic vision is rooted in psychodynamic practice, in which the life drama represents an attempt to come to terms with primitive forces over which the actor has little or no control. Life's journey is less a romantic quest than a painful struggle to access repressed memories. To paraphrase Sigmund Freud, the goal of therapy is to translate neurosis into ordinary unhappiness. Finally, we have what can be described as the comic vision. The term is used here not to refer to comedy in the contemporary sense but to a situation characterised by confusion in which the actor or actors fail to achieve their objectives because of dysfunctional behaviour. The best examples in Shakespeare are *As You Like It*, *Twelfth Night* and *Much Ado About Nothing*. In each of these plays, through a learning experience, a new understanding emerges and social and personal goals are achieved. The equivalent in the world of therapy is CBT.

On the face of it, these three positions seem incompatible and thus there can be no unified discipline of counselling psychology. However, there is an option towards an ironic position which attempts to reconcile all these positions. This involves a willingness to aim at detachment, seeing all sides of an argument and to achieve some form of synthesis. It requires the ability to think dialectically in reflecting upon practice and to work towards a personal integration. Without the ability to think ironically across traditional boundaries, it is doubtful whether there can be a discipline of counselling psychology – just psychologists who work within their own individual paradigms. Dialectical thinking will be discussed further and its importance reinforced in the conclusion to this chapter.

THE SCIENTIST-PRACTITIONER

While clinical psychology owes its early development to its links with medical practice, its modern format and success since the Second World War owes a great deal to the manner in

which it has incorporated and internalised a coherent narrative about itself, namely that of the scientist practitioner. This began to take shape in the 1950s after a conference held by the American Psychological Association at Boulder, Colorado, in 1947, when the model was officially endorsed by the American Division of Clinical Psychology. In the model, clinicians are perceived as applied scientists, drawing on the science of psychology.

It has been subjected to considerable scrutiny with both high levels of endorsement and severe criticism (see Blair (2010) for a critical review of the concept). Despite evidence that the model is rarely fulfilled in practice and that scientists and practitioners have different objectives, it remains a potent narrative reinforced by the contemporary emphasis on evidence-based practice defined as empirically supported treatment protocols. The model was, and perhaps still is, well suited to clinical psychology whose origins derive from an experimental and medical background. In contrast, and on the face of it, it appears less well suited to counselling psychology which, coming from a humanistic tradition, has favoured a more multi-dimensional approach in which the relationship between psychologist and client has been emphasised as a critical factor.

However, to polarise the situation in this way runs the risk of over-simplification. An important question is what constitutes evidence and whether randomised controlled trials are the only form of reliable and valid evidence? As Blair (2010) points out, randomised controlled trials offer an indication of what works best for a particular client group, not what is best for an individual client. Thus the challenge for counselling psychology is to expand the definition of what constitutes evidence in a way that retains its credibility as a form of scientific practice. This involves building a bridge between the various positions, a challenge taken up by Corrie and Callanan (2001). They suggest that we can think about the scientist-practitioner model as itself a continuum from a closed model prioritising prediction and control to a more open model where psychological evidence might be used in a more holistic manner according to the needs of a given enquiry. Lane and Corrie (2006) refer to a need to find a 'mid-point between being purely pragmatic and the experimentally rigorous, suggesting a more liberal, flexible and stakeholder focussed basis' (p. 16).

The message is that in applying the scientist-practitioner model to the real world of British psychological practice, there is no virtue in situating counselling and clinical psychology in two opposed camps. While there may be differences of emphasis, we should not create straw men or women that we can then knock down with a flourish. The reality on the ground is that members of the two disciplines frequently work alongside each other, often with very similar client issues. The Division of Clinical Psychology (2011, p. 13) refers to the main therapies used by NHS clinical psychologists as CBT, systemic, psychodynamic and CAT. Add person-centred and existentialist to this list and we probably have a statement of the main therapies used by counselling psychologists. Nevertheless, as already indicated, counselling psychology has chosen to move away from a single-model approach which tends to characterise programmes of training in clinical psychology but also in counselling and psychotherapy.

Given that counselling psychologists employ much the same techniques as clinical psychologists and counsellors/psychotherapists, does the difference reside in the emphasis on reflective practice? It would be absurd to argue that clinical psychologists are not reflective in

their practice. Taylor (2003) has deconstructed the use of the reflective-practitioner model within the NHS in the context of nursing. She perceives it as foremost a disciplinary practice that is part of a confessional structure. However, she adds that 'to confess sins of omission or commission is acceptable so long as these are part of a process of learning and development' (p. 248). Commenting on this, Lewis (2008) suggests that the point Taylor is trying to make is that as an account of the client, a reflective account is no more authentic than a case formulation. However, reflective practice for a counselling psychologist 'aligns with practice in a more fundamental way' (p. 64) by 'foregrounding the use of self in the therapeutic process' (p. 63) and it is this fact that puts reflective practice and the reflective practitioner at the heart of counselling psychology. In this context the requirement for personal therapy in approved programmes of counselling psychology training provides some distance from other disciplines.

COUNSELLING PSYCHOLOGY AND HELPING OUTSIDE THE HEALTH SECTOR

Almost inevitably much of this chapter has focused upon the health sector, but of course counselling psychology also exists in fields such as education, employment, organisational development and coaching. While the notion of helping may have slightly different meanings in these contexts, what most have in common is that feature of counselling psychology that emphasises well-being rather than sickness. The growth of coaching psychology is an excellent example with its focus on the development of life skills rather than responding to crisis. The whole positive psychology movement reflects this movement away from helping as a response to pathology towards a focus on helping as a movement towards self-actualisation. It is notable that counselling services within universities now frequently describe themselves using the language of offering support and facilitating well-being.

CONCLUSION: A DIALECTICAL WAY OF THINKING

The map of the world of helping is in a constant state of flux. The bit of that world known as counselling psychology reflects this dynamism. It looks very different in 2013 than it did in 1992 when it became a division, and even more so than in 1982 when it became a section within BPS. At that time, evidence-based practice was just a gleam in the eye, IAPT did not exist, NICE likewise, and HCPC (Health and Care Professions Council) and statutory registration was a long way away. In 2015 or beyond, when you read this chapter, it may have changed even more than in 2013/14 when the chapter was written. It follows that any map has to be flexible enough to offer not just a snapshot at a particular point of time but to take account of movement and change.

The idea of a dialectical process, which derives from the work of Hegel and Marx, offers a framework for this. It has already been adopted in this chapter in the discussion on the role of ironic thinking. In its classical form the basic concept is that ideas that frequently start out as opposites eventually come together in the form of a synthesis. In politics this is reflected in movement of the two main parties towards the middle ground. The end product is more than a sum of its parts. Thus a thesis is opposed by antithesis which eventually coalesce together as a synthesis. This synthesis then forms the new thesis which we can think of as the orthodoxy. In time this generates an antithesis leading to a new synthesis and so on and so on *ad infinitum*. Apply this analysis to counselling psychology and what we find, as this chapter has suggested, is that the discipline developed as an antithesis to the contemporary thesis as represented by key ideas dominating clinical psychology and psychiatric practice. However, over time, the philosophy behind counselling psychology has filtered into and been taken on board by the wider psychological world, while counselling psychology for its part has had to broaden its outlook in order to recognise the imperatives of this wider world. Conceiving of the world map in this manner, the philosophy of counselling psychology is now part of the new thesis/orthodoxy.

Over time a new antithesis will develop and indeed it possibly already exists in the form of a more politicised perspective which emphasises the need for psychologists to work towards social justice and to oppose any use of psychology which might perpetuate inequality or oppression. This is sometimes described as critical psychology. This places the practice of the psychologist within a wider social and political context. This is exemplified in a book by Proctor et al. (2006) entitled *Politicizing the Person-centred Approach*, and the community psychology approach of Kagan et al. (2010).

Looked at this way, counselling psychology can be regarded as a success. While it is unfortunate that the discipline lags behind clinical psychology in terms of resources devoted to it, we need to remember Joseph Stalin's rhetorical question about how many battalions the Pope had. Stalin's empire is long dead but the Papacy, whatever we think about it, remains powerful. Mindful of this, we should not evaluate the influence of counselling psychology by measuring numbers or resources. My view is that it has something good to offer in the form of its philosophy and methods and has succeeded in convincing a wider world of the value of its product. Recent publications referred to in this chapter by the British Psychological Society on formulation and psychiatric diagnosis respectively demonstrate that radical challenge to established positions does not solely exist within the Division of Counselling Psychology.

In 2009, Mollon, a clinical psychologist, wrote about what he saw as the corrupting influence of NICE, with its emphasis on identifying specific protocols for specific diseases replacing 'the nuances of individual experience' (2009, p. 130). He posed the question, 'Why are counselling psychologists not angrier with clinical psychologists?' However, I venture to suggest that this is an overgeneralisation of what differentiates the two divisions and that there is no merit to be had in being envious of clinical psychology or in adopting a defensive posture of splitting the world into good and bad. Counselling psychology is not a passive recipient of the world in which it exists and of the changes which go on all around it. It does have the power of agency to relocate itself. It does have a choice. It can work to further establish itself and strengthen its

position within the new thesis as part of the dominant group. Alternatively, it can seek to work to integrate its focus on the reflective practitioner with newer, more radical ideas such as those outlined above.

So where does this take us in terms of defining what is counselling psychology and identifying a role for it? Blair (2010, p. 20) describes it as 'situated at a busy junction of diverse and sometimes competing ideologies, frameworks and paradigms'. It is a body of knowledge but much of it shared with other disciplines. It is a form of practice but again shared with others. At its most basic, it is a division of the BPS with a specific set of principles but the divisional structure may not last for ever. There has been discussion of something akin to a college of all psychologists working in the field of health and incorporating and thus replacing divisions. Perhaps there is an understandable fear were that to happen that all would be lost; what Bion (1962) described as 'nameless dread' (what cannot be spoken about) would come to pass. However, my view is that this fear can be confronted. The possibility, even likelihood, exists that the philosophy and disposition of counselling psychology would not be lost, but on the contrary would enter even more into the practices of other helpers. After all, in the field of helping, if one has something good to offer, the ethical position is surely not to keep it to oneself but to give it away so that its benefits are disseminated as widely as possible.

For an exercise on models of helping see the companion website **WL1**

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