

THE CENTRALITY AND CONSISTENCY OF COUNSELLING PSYCHOLOGY: BEFORE, DURING AND AFTER 2008

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Abstract: Counselling psychology's philosophy remains constant, that is, to work with clients presenting issues in the context of the therapeutic relationship and to attend to inter and intra-personal factors. Another constant is the endeavour, as we, as psychologists, try to understand the origins, presentations and containment of human experience in the therapist's room. Can counselling psychologists hold on to these central beliefs when the 'wind of change' is blowing? One of the current 'winds' in the United Kingdom National Health Service (NHS) is the situation created by clients' need for talking therapies and the introduction of substantial resources to fund the creation of new training posts, where the focus is on cognitive behavioural therapy. How will counselling psychologists react to this development bearing in mind their research-supported beliefs that underpin their discipline? This article aims to discuss arguments and debates that surround the emergence of an apparent threat to the current position of counselling psychology.

Key words: Counselling psychology, U.K. National Health Service

INTRODUCTION

At first glance, this perhaps looks like a considerable length of time to address, namely from 1982 (when the Counselling Psychology Section was formed, within the British Psychological Society) through to 1992 (when the British Psychological Society's Division of Counselling Psychology was set up), and then 16 further years forward to the present time. However, if we are thinking about Counselling Psychology's *philosophy*, then this does have a *centrality and consistency* that spans across these years.

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There are many statements of the philosophy of Counselling Psychology; perhaps one that has a meaning for me comes from Chapter 1, in *The Handbook of Counselling Psychology*, edited by Woolfe, Dryden, and Strawbridge (2003). These central points of philosophy can be summarised as: (a) clients presenting issues are heard as described in their subjective experience, (b) these issues are heard in the context of the therapeutic relationship, usually individually on a one-to-one basis, but also in group settings, (c) the meaning that these issues have to the respective client is aimed to be understood in the therapeutic relationship; beliefs are also considered in context, (d) these processes are constructed by the client both in inter-personal interaction and within the person themselves – hence, both inter- and intra- personal factors are involved.

The Counselling psychologist's professional training is rooted in theory, but no particular theory is held as dogma. Theories are helpful as they inform the client's view of the world and assist in working with presenting difficulties. This means that different theories can be included as long as they fit in with the criteria of the philosophy and have a reliable research base. The nature of that base may be in evidence-based practice, and also in practice-based evidence.

Counselling Psychology is not exclusive in its theoretical choices. Its philosophy does however emphasise that the client's work is done in relationship. It is important how and when the client feels, thinks, and acts in the way that he or she does; how this might be changed; how resistant this might be to change; or how this may be accepted.

The aspect of causality (i.e., *why* the client feels or thinks in a particular way) usually remains at the level of hypothesis. These conversations can be put together as 'formulations' that are hypotheses put forward to explain the client's experiences. In some ways formulations are the cerebral or intellectual descriptions of the client's experience. Within this is the interface between one person (therapist) and another (client), where so much has the opportunity to be communicated. The counselling psychologist aims to be receptive to the communication to assist the client.

Counselling psychologists work in the language of formulation and not the language of diagnosis. Yet there is a need to know the language of diagnosis as clients themselves use this, as do other professionals that are involved with the client. There would be a focus on the quality of the relationship, so that ways of working that aspire to be 'efficient', manualised and standardised are not preferred.

Clients' experiences

Let's look at some casework to understand the application of Counselling Psychology. An elderly man is referred to therapy with recurrent nightmares and depression

(understood here as suppressed feelings). He had epilepsy since early twenties that has resulted in serious accidents and relationship difficulties. The man is able to begin to work through the losses in his life connected with his epilepsy; the manner is similar to the grieving process. He continues to be puzzled by his nightmare. When he becomes able to self-suggest what the dream may mean for him, he begins to accept his current life position. He begins to realise the origins of some of his sad and angry feelings; he can see that he has control over some of the events that happen in his life, but little control in other situations.

A man is concerned about his lack of ability to be spontaneous in personal relationships with the opposite sex; he can't commit to one person and has a number of relationships open at the same time. A part of him realises that the early loss of his mother is associated in some way, but it is only when he explores this in therapy, and finds that he wants to stay connected with the therapist, that he realises his difficulties in letting go and separating. He recognises that he has been defending against the awful finality of death and the subsequent loneliness and lack of belongingness.

A man is misusing alcohol and is described as 'depressed' in the doctor's referral letter. When he describes his life experience, it is recognised by the therapist that he has helped others continuously throughout his life. He feels empty. In the transference he describes a feeling of being heard in the sessions and this reminds him of his maternal relationship. He also connects with the loss of his mother when he was 10. He comes to realise that he has continually helped others to avoid the pain of this early separation through her death. He grieves her afresh and comes to realise his own need to be cared for as well as caring for others. His need for alcohol becomes less dominant and is eventually moderated.

These are just some examples of clients' life stories. The *consistency and centrality* here is seen in the fact that each client's story is individual, special and particular to him or her. Centrality and consistency is seen in the *difference* of each. The counselling psychologist in working with the client tries to find meaning in each person's experience, so that he or she can manage his/her life in a way that is less affected by distress. The feelings of depression that are so often the *described presenting issue*, actually have underlying feelings that can be understood as sadness, loneliness, frustration or anger, depending on the client's story. In addition, learnt thinking patterns may be entrenched that re-iterate these feelings. Clients' stories consistently include difficulties in affect (feelings), cognition (thought) and behaviour. These domains are consistently involved as they comprise the person's experience.

A woman who has lost her father several years ago is still in the early stages of grieving and cries regularly. She is concerned that her grief is continuing. In therapy she realises that she has been the member of the family who has taken on

responsibility for the upset of all the other family members. This becomes clear in the narrative of the work in therapy, and the therapist challenges her thought process. With increased insight, the woman becomes aware of her thinking patterns and begins to stop taking on others' responsibilities. She eventually works through the grieving stages and is able to complete therapy.

Disturbed early relationships

Sometimes, there is so much disturbance in the development of the clients' life, that there is no sense of emotional stability. In cases such as this the client is often described diagnostically as having a personality disorder. These clients usually have a history of childhood disturbance (real or perceived), which includes sexual, emotional or physical abuse. Their internalised parental others may be critical and rejecting, or only relate to the child in terms of what he or she can do for them, almost treating the child like an 'object' not a person. When the client is engaged with life experiences, their intra-personal relating is self-critical and at times self-harming or suicidal. The child has often built coping defences or survival techniques that have become so entrenched that by adulthood these behaviours are not successful in protecting the self, they may be maladaptive and even harmful.

Counselling psychology has the theoretical background to understand and work with such people, but the time that is required to provide a consistent internalised parent (therapist) is often lengthy. Burton's (1998) text is excellent in its explanation of the association between the effect of early losses and the need for full assessment of this, and if relevant, longer-term therapy.

Consider the example of a young girl who has been consistently emotionally abused and criticised by her mother as being 'a waste of time' and 'bad through and through'. Her father was violent and left the family home when she was two. Family stories of him said that he was 'no good'. The young girl tried hard to manage her life. When things went wrong, she turned to her mother for help, but she was constantly rebuffed and asked to do some household work. She felt alone, always hoping that if she did enough in the home she would be praised and have affection, but this never happened. She thought she was a failure and bad and often tried to self-harm. This is a typical pattern of a person who has had abusive early years. It is a familiar story in therapy, with this pattern of parenting. Therapy is often seen to 'fail' such people due to the strength of the early learning patterns, and the length of therapeutic time that is needed to develop a sense of hope and self-belief.

Which therapy and what outcome?

Does it matter which therapy is used? Thorough assessment is helpful to indicate short or longer-term work. Roth and Fonagy (2005) would say that as long as the relationship remains the focus, then working humanistically, cognitively or dynamically can each be helpful; the counselling psychologist often utilises integrative approaches to working with clients.

However, personality disordered clients may need much longer-term work that is underpinned by cognitive and dynamic theories. The outcomes of all therapy sessions are not always considered a cure by the client. This is realistic. For example, multiple bereavements after therapy may result in the client feeling less depressed, but there may be a sad acceptance. Ongoing anxiety from early maternal rejection, after therapy, may result in an increased insight into the roots of the anxiety, and also an ongoing need to manage these feelings. Therapy is not the panacea for all ills. It is a realistic multi-theoretical basis for understanding and working with human distress. It appreciates the difference of each individual.

There is individual difference, yet there is *consistency and constancy* also in the fact that people are generally upset by real and/or perceived threats to the self. If the self is in psychological danger of harassment, embarrassment, shame, ridicule, fear or anxiety, or any of the emotions concerned with hurt (i.e., resentment, anger or disappointment), then the person will set up a defence to protect from further distress. This defence (e.g., withdrawal, avoidance, denial, repression) may or may not serve a protective function. These all function to assist the safety of the self, but in doing so, set up further problems by rendering the person less socially available. The counselling psychologist is well-placed to understand the person's system and to work with them to find meaning, see the development of core-beliefs, see the origins of negative automatic thoughts, understand the defences, and stay with the client as they unpack their experiences.

As far as research goes, the counselling psychologist can draw on research studies carried out by researchers from a variety of perspectives. What is the domain of the counselling psychologist's research?

The research agenda

In the *Handbook of Counselling Psychology*, edited by Woolfe, Dryden, and Strawbridge (2003), there are three chapters concerned with research and evaluation. These represent an overview of quantitative and qualitative research on psychotherapeutic interventions over the past 50 years. Chapter 4 by Barkham and

Barker (2003) focuses on practice-based evidence and locates this firmly in a model that integrates practice-based evidence with evidence-based practice. Networks for organising practice-based evidence would benefit from further exploitation.

Does the discipline of counselling psychology have a research field that is particular to this discipline alone? What makes a research study the precinct of counselling psychology? I would argue that counselling psychology's research field can extend to being described as the area of psychotherapeutic intervention, and hence is a wide umbrella. Consequently, research by counsellors is relevant to counselling psychologists. A search over past issues of the *Journal of the British Association for Counselling and Psychotherapy* finds articles that involve data collection about the outcomes from therapy, the application of therapy to a range of client issues; articles about different research methodologies. Articles in this sister discipline are of benefit to the counselling psychologist. They are perhaps at the point of overlap with the counselling psychologist in terms of philosophy and professional content.

Looking back through the years in *Counselling Psychology Review*, the articles are more discursive; fewer involve data collection; many comment on the practice use of different approaches. Perhaps 12-14 years ago articles often had the word counselling in the title; almost as though the discipline of counselling psychology was emerging and separating from that of counselling. A part of the *British Journal of Psychology and Psychotherapy* is more specifically devoted to empirically-based studies from counselling psychologists. The umbrella of counselling psychology is wide enough to incorporate the findings from all of these to inform the therapeutic relationship.

Could it be that counselling psychology can't claim a distinct boundary around its research field? Is this possibly because of the overlap between professionals in terms of theoretical applications and practice outcomes? Is this because there is so much overlap of professional practices between counselling and psychotherapy? Could it be that counselling psychology's research field is predominately practice-based evidence? Do we need to argue long and hard that Randomised Controlled Trials are not the way in which meaningful evidence is collected? Certainly Rowan (2001) agrees with this viewpoint when he says that superficial approaches like Cognitive Behavioural Therapy (CBT) for symptom reduction can be evaluated using superficial symptom-based evaluations. Deep-rooted explorations of experience and personal change will not be accessed by superficial evaluation techniques. Can this kind of change be evaluated at all?

Interestingly, the salient factor from many studies is that the nature of the therapeutic relationship is the single most therapeutic factor. However, what does this mean? Is it the core conditions from person-centred work of empathy,

congruence and unconditional positive regard? Is it trust, consistency, respect and clarity? Is it working with concepts in the relationship like congruence, transference and counter-transference? Some answers to these questions are found in Barkham and Baker's (2003) chapter in the Handbook of Counselling Psychology, where they state that the client's ratings of the therapeutic alliance are the most predictive of outcome. They also state that the *components of alliance* have not been fully researched in terms of the clients' descriptions of these.

Research from a related field into the nature of subjective well-being is suggesting that there could be a personality variable in the beneficial outcomes of therapy. The concept of extraversion is associated with subjective well being. Could it be that personality might be an indicator of the benefit from therapy in the direction of those with a more openness being more likely to show beneficial change after therapy?

Where does this place the centrality and consistency of the research agenda for counselling psychology at the current time? Whilst the location of the philosophy underpinning practice is unchanging in the development of counselling psychology since 1982, the research agenda is wider and has no specific focus and no specific British Journal of Counselling Psychology. Is the apparent lack of a research focus perhaps a strength in the way that it allows many topics to be investigated and research material incorporated from related disciplines? However, perhaps it is a weakness as the discipline of counselling psychology cannot be easily defended in the face of challenges, criticism or political action that apparently fails to appreciate its value. Is the very nature of the research field, that is, *people's life experience and their varied response to trauma and difficulty*, so diverse that it is not possible to form a focus?

UK COUNSELLING PSYCHOLOGY IN THE NATIONAL HEALTH SERVICE IN 2008

The embracing discipline of counselling psychology and the counselling psychologist as a *therapist* is now under threat in National Health Service (NHS) UK Trusts. This possibly includes colleagues in clinical psychology in their therapeutic role. This may appear to be a dramatic statement, but I will explain how I come to make such a statement, which I own as my statement, and I am willing to be challenged on this perspective and to discuss it.

The following picture has been emerging since 2000. More clients have been asking for talking therapies, more doctors have become aware of talking therapies, research studies have been published in the media that say anti-depressants are not helpful in the majority of cases (except for more severe depression), more research

studies have been published in the media that say that cognitive-behavioural therapy (CBT) is helpful as a response to anxiety and depression. Research has been published that has shown the advantages of cognitive therapies in working with clients who hear voices and may have some psychotic features.

Mental Health Trusts in the NHS have built up long waiting lists of clients for therapy. The government's agenda is to reduce waiting times to be seen to 11 weeks and eventually less. Taking stock of the two years or more waiting times a couple of years ago, this has been deemed unacceptable by the government and procedures have been put in place so that clients can see someone as quickly as possible after referral by the doctor (GP). This system has come to be known as the Stepped Care model. Typically the steps in this model move from GP or practice nurse referral to:

Step 1. A psychometric assessment of anxiety (British Anxiety Inventory, BAI) and depression (Patient Health Questionnaire-9, PHQ-9) by a case manager (who would be a mental health practitioner), including an assessment of risk, to:

Step 2. If depression is mild, then guided self-help, CBT, Computerised CBT from a primary care mental health worker (low intensity worker, part of the Improving Access to Psychological Therapy programme, IAPT) or counselling; and/or medication;

Step 3. If depression is more severe, then the same range of treatments, delivered by the same range of professionals, but a high intensity worker (IAPT); also possibly a *psychologist*;

Step 4. If depression persists and is described as 'treatment resistant', recurrent, atypical and psychotic, then complex psychological interventions are appropriate from a *psychologist*; medication;

Step 5. If there is high risk of suicide then the Home Treatment team is likely to be involved.

The Doncaster model (IAPT) as discussed by White (2008) is suggesting that there are benefits in a Stepped Care model. He comments in the article on numbers of clients who have been assigned counselling or CBT by the case manager. This shows that clients have continued to be assigned to counsellors as well as to those trained through the IAPT model (i.e., low or high intensity worker) using CBT. It has also allowed counsellors to broaden their ways of working by becoming familiar with Computerized CBT (CCBT), because their waiting lists are shorter as a result of the role of case managers. Counsellors also say that they can allow more sessions for longer term work.

The government has launched 300 million pounds over the next three years into the IAPT agenda (a scheme for training workers in CBT) which will gradually result

in more workers able to offer CBT for depression and anxiety. Waiting lists are reducing, but is this a rationalisation for efficiency, at the expense of quality? What will be the effect of the increase in workers trained by the IAPT programmes on psychologists in the NHS? One way of trying to answer these questions is to look at what may be helpful and what may be not helpful to the clients themselves and the mental health context:

(a) *Helpful?* Able to talk to someone more quickly than before; see a case manager who assesses whether the next step is self-help, CCBT, counselling or CBT therapy (IAPT: low/high intensity); receive one of the above ‘interventions’; symptoms of depression or anxiety probably reduced as interventions are focussed on symptom reduction (research supports the reduction of depressed symptoms using CBT); psychometric test describes level of severity of issues; workers are less expensive than the chartered psychologist; psychologists can be retained for the later steps, i.e., Steps 3 and 4.

(b) *Hindering?* The person may see different mental health professionals and hence continuity of relationship is lost; symptoms may be alleviated, but *later* reappear; presenting problems may not have been addressed in context, as symptoms only have been assessed and not the complex nature of the issues; there are other presenting problems, not just depression and anxiety; although psychometric scores have been taken, the level of severity of upset may not be appreciated – for example the impact of early losses may not have been taken into account and personality disorders may be overlooked.

Perhaps one of the central issues of debate comes from within the heart of psychology. Is it possible to change or re-frame thoughts and behaviours without being aware of the origins and sources of the way in which a person thinks, or the context in which the behaviour occurs? A strict behaviourist would say that it is not essential to change cognition to change behaviour. A cognitive approach would say that it is not necessary to know the developmental origins of a thought pattern to begin to challenge its irrationality. Both these viewpoints have research to say that behaviour change and cognitive change is possible. The counselling psychologist would not disagree with these views; however, most counselling psychologists would regard both behavioural or cognitive approaches alone as rather narrow and reductionist in an understanding of the person.

One has only to return to the philosophy of the counselling psychologist to see that a CBT approach *alone* is theoretically weak and not sufficient to provide a person with a full approach to coping with his or her issues, particularly when these issues are complex.

Psychologists' place in the stepped care system

Nevertheless, what is the place now of the psychologist in the stepped care system? In answering that question, a look back through the last 3 years may answer some questions. The New Ways of Working for Applied Psychologists (NWW-AP) project was established in July 2005, reporting back in July 2007, as part of a wider programme looking at modernizing mental health services. There were seven psychology project groups, focusing on new roles, career pathways, improving access to psychological therapies, training models in applied psychology, organizing, managing and leading services, working in teams, and mental health legislation. Throughout the project an applied psychology stance was taken and there was full involvement by the counselling psychology representatives in all the project groups.

I was a member of the Core Group for the NWW-AP project and particularly recall the contributions from service users during the meetings of the project. The emphasis here was to keep in focus the needs of service users.

For counselling psychologists outside the NHS, the requirements and demands of the NHS are not relevant to a significant number of members and there is a danger in allowing those requirements to dominate the development of the entire profession. For counselling psychology in particular this is an acute difficulty, because we estimate that around half of the profession work for at least part of their time in the NHS, which means that half do not, and the profession itself is founded on values and philosophies that sometimes sit uneasily alongside NHS practices. Therefore engagement in NWW-AP and similar NHS projects, working parties and committees is never going to be straightforward for counselling psychology.

Since 2007, the government modernisation agenda is proceeding rapidly and having an increasing effect on the availability of psychology posts. Applied psychologists are expensive to employ, and so must be able to offer 'added value' over and above the contribution made by less expensive colleagues such as community psychiatric nurses and CBT therapists. Is the counselling psychologists' therapy role being eroded by other workers who can carry out manualised therapies? Where does this leave counselling psychologists? Are we expensive therapists whose work can be done by lesser-qualified workers? Are we compromised by our apparent similarity with counsellors and psychotherapists? What argument would you put forward to continuing to employ counselling psychologists? The answers to this question may vary depending on primary care or Community Mental Health Team contexts.

THE FUTURE FOR COUNSELLING PSYCHOLOGY IN THE NHS

Arising from the NWW-AP it seems that there will be an increased recognition of the part played by psychological factors in both physical and mental ill-health, and a consequent acknowledgement of the importance of psychological understanding and skills in treatment planning and delivery in both primary and secondary care. However, although psychologists are involved in levels of care, they may not always be the professionals delivering the therapy.

Primary care

Historically, therapy has been provided in the NHS by counsellors, clinical and counselling psychologists. Will it continue this way? Primary Care departments have been placed in a position where they have had to tender for the contract to continue their work. Those who have been successful in obtaining contracts are those who have made use of a new Government development as described below.

The Improving Access to Psychological Therapies project (IAPT) and the changes to professional roles and responsibilities seen in the new Mental Health Act of 2007 are integral developments in the New Ways of Working. Turpin (2005, 2007) has given a thorough discussion of the IAPT project as it applies in England. Beginning with the recommendations of Layard (2004, 2006), and initial outcome data from two pilot sites, IAPT envisages a network of psychological therapy centres in primary care where short-term CBT will be widely available to the public as part of a stepped-care mental health and well-being structure. The IAPT programme is putting forward in-service posts for what is described as low and high intensity workers. Training in Universities and working in the NHS practice setting is the shape of the work. Fully qualified clinical and counselling psychologists are even being asked to train on an IAPT programme which is CBT based only. The onset of the IAPT programme is accredited by the British Association for Behavioural Cognitive Psychology; some psychologists are feeling side-lined and pushed aside. Discussions are on-going within the British Psychological Society (BPS) about this development.

How can the philosophy of counselling psychology sit with this agenda? If jobs are scarce, the qualified counselling psychology may have to incorporate the IAPT/CBT training. Does this make logical sense?

The trend is towards an increasingly streamlined workforce, with more generically trained workers providing shorter and more standardised treatments as cost pressures mount across the NHS. The emphasis on short-term CBT in IAPT, and the increasing number of posts for generically trained 'psychological therapists' are

examples of this. Any added value is likely to be seen in terms of supervision, consultancy and clinical leadership. Chartered clinical and counselling psychologists will also probably be required to see more complex clients whose presentations do not fit 'anxiety and depression' and who may also have elements of personality disorder.

Secondary care

The new Mental Health Act of 2007 replaced the role of Responsible Medical Officer with that of Responsible Clinician (Department of Health, 2007), with the expectation that senior applied psychologists in the NHS will take on the role in addition to consultant psychiatrists. The Act thereby recognises the place of psychological understanding alongside psychiatric expertise.

Practitioners from both clinical and counselling psychology are relating their clinical experience and are aware of the complex needs of some clients in secondary care. For example, clients who are described as having a borderline personality and those with both mental health and drugs and alcohol problems often have complex needs. There is an on-going role for counselling psychologists in the NHS to constantly be shaping the use of the work-force, where their thinking is driven by psychological formulation and practitioner experience.

The secondary care context comprises psychiatrists, community psychiatric workers and social workers and is located in Community Mental Health Teams (CMHT). Here the role of the counselling psychologist is as a therapist, as a supervisor of non-psychologist health professionals to encourage the language of formulation, and as a leader of services. Other professionals in the CMHT, namely psychiatrists and community psychiatric nurses are most usually trained in the language of diagnosis; there are hierarchies of relationship where the psychiatrist is in a role that historically has been the lead role. Perhaps this is because they hold the power of prescription, as people's distress in secondary care often needs medication to bring it into manageable control. Languages of diagnosis and formulation can cause complexities for the client. How should they understand their distress when they are offered only medication and a diagnostic label from a psychiatrist who holds a powerful status figure?

It may be that the future for counselling psychologists in health lies outside of the NHS, in private consultancies with whom the NHS may contract to manage, supervise and/or deliver services. The challenge to counselling psychology will then be to hold on to its core philosophy in a more commercial environment.

The Statutory Regulation of Psychologists with the Health Professionals Council is planned to occur during 2008, bringing to a focus the need to have registration at

chartered level. The concept of accredited pre-chartered training arose from the New Roles group in NWW-AP and was being explored in the BPS; however, the IAPT programme has cut across this.

Proposed pre-chartered applied psychologists, rather like the existing assistant psychologists would be able to offer psycho-education, run anxiety and stress management groups, identify those with complex needs, deliver CBT programmes under supervision, assist in preventing the onset of psychosis, offer active listening where appropriate using basic counselling skills. All these tasks would occur under the supervision of a chartered psychologist. However, the development of these roles is not progressing with speed.

So, given the above, can the contribution that counselling psychologists have made to the field of therapy be sustained in the future, whether within or without the NHS? Can they sail with the wind of change, or will they be blown off course?

One way of looking at this is that counselling psychologists provide a continuing reminder that patients are people, and that people exist in relationship. It is all too easy when faced with long waiting lists, severe distress and disturbance, and the demands of a large bureaucratic organisation, to adopt a dehumanising medical model of treatment. Clinical psychology colleagues have defended a therapeutic position in the NHS for many years, and counselling psychology, less rooted in NHS culture, has been able to reinforce that and extend it further, guided by its core philosophy.

The constant threat to the development of NHS counselling psychology will probably be in the form of tensions produced by competition and professional jealousies in an atmosphere of difficult work-related content and diminished resources. Can this be contained? Work by Obholzer and Roberts (1994) is helpful in looking at dynamic factors in organisational development. The challenge is to hold on to all that is good in our profession, our beliefs in our central philosophies, whilst fully engaging and sailing with the wind of political change.

REFERENCES

- Barkham, M., & Baker, C. (2003). Establishing practice-based evidence for Counselling Psychology. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.), *Handbook of counselling psychology* (pp. 93-117). London: Sage.
- British Psychological Society (2007). *New ways of working for applied psychologists in health and social care*. Leicester, UK: British Psychological Society.
- Burton, M. (1998). *Psychotherapy, counselling and primary mental health care: Assessment for brief or longer-term treatment*. Chichester, UK: Wiley.

- Department of Health (2007). *The Mental Health Act*. Retrieved on December 2008 from: http://www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en_1
- Layard, R. (2004). *Mental Health: Britain's biggest social problem?* London: Cabinet Office.
- Layard, R. (2006). The case for psychological treatment centres. *British Medical Journal*, 332, 1030-1032.
- Obholzer, A., & Roberts, V. Z. (Eds.). (1994). *The unconscious at work*. London and New York: Routledge.
- Roth, A., & Fonagy, P. (2005). *What works for whom? A critical review of psychotherapy research*. New York: Guilford Press.
- Rowan, J. (2001). Counselling psychology and research. *Counselling Psychology Review*, 16, 7-8.
- Turpin, G. (2005). New ways of shaping and delivering psychology services. Reflections after the NIMHE/BPS Conference in Birmingham, February 2005. *Counselling Psychology Review*, 20, 56-57.
- Turpin, G. (2007). *Good practice guide on the contribution of applied psychologists to improving access for psychological therapies*. Leicester, UK: British Psychological Society.
- White, D. (2008). Good going at the Doncaster IAPT. *Therapy Today*, 19, 10-14.
- Woolfe, R., Dryden, W., & Strawbridge, S. (Eds.). (2003). *Handbook of Counselling Psychology*. London: Sage.