Contents

3 Editorial: Counselling psychology and Theory: From Immanuel Kant to Charlie Brown
Naomi Moller & Terry Hanley

Theoretical Articles:

8 The identity of counselling psychology in Britain is parochial, rigid and irrelevant but diversity offers a solution
Naomi Moller

17 Mental health and 'The Big Society': Where do counselling psychologists and therapists fit in?
Dawn Edge & William West

24 Case formulation within a person-centred framework: An uncomfortable fit?
Jane Simms

38 Integration in counselling psychology: To what purpose?
Laura Cutts

49 Cognitive Relational Therapy
Yvonne Walsh & Alan Frankland

57 Is it time we turn towards 'third wave' therapies to treat depression in primary care? A review of the theory and evidence with implications for counselling psychologists
Salena Bhanji

70 Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: A discussion of cognitive behavioural therapy, mindfulness, and mindfulness-based cognitive therapy
Jennifer Ellen Dayes

Book Reviews:

77 Living with Voices: 50 Stories of Recovery
Prof. Marius Romme, Dr Sandra Escher, Jaqui Dillon, Dr Dirk Corstens & Prof. Mervyn Morris
Reviewed by Amy Dodd

78 Pluralistic Counselling and Psychotherapy
Mick Cooper & John McLeod
Reviewed by Clare Lennie
Celebrating Pluralism in Counselling Psychology?

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Editorial: Counselling psychology and Theory: From Immanuel Kant to Charlie Brown

Naomi Moller & Terry Hanley

‘Experience without theory is blind, but theory without experience is mere intellectual play.’

(Attributed to Immanuel Kant)

With some trepidation we decided to focus this Special Edition upon theoretical developments within the field of counselling psychology. On putting out such a broad call for papers, we had very little idea of what the fruits of our labour would be. Questions such as, ‘Would anyone contribute?’ and ‘Would we receive anything of a sufficient quality?’ played on our minds. Here we present the end result, a product that in itself answers the former question (people did indeed contribute). In relation to the second question, the breadth and wide ranging nature of topics is clearly evident within the titles of the papers. Likewise we are sure that the content will provoke numerous interesting questions, however, we will leave the judgement of its quality to you, the reader.

In a previous editorial of Counselling Psychology Review the issue of ‘What is research?’ was considered and, given the subject matter of this Special Edition, it only seems apt to put theory under the microscope and do it a similar injustice. So, ‘What is theory?’ Is it purely a means of keeping academics in jobs? (‘A professor must have a theory as a dog must have fleas’ [Mencken, 1919, p.12]), or is it something more? The maxim attributed to Immanuel Kant at the beginning of this piece reflects some of the riches that we would argue resonate with the profession of counselling psychology. It is a profession that encourages a dialogue between the experiential and theoretical. More specifically, to become a counselling psychologist and be eligible for chartered status within the UK, individuals in training have to offer therapy to others and attend personal therapy themselves. Accompanying this, they have to meet Doctoral Level training criteria reflecting understanding of theory and accomplishments in research. So, undoubtedly theory is important and it impacts upon what we do, but what is it?

To cite a more recent sage-like entity, Wikipedia notes:

‘Originally the word theory is a technical term from Ancient Greek. It is derived from theoria, θεωρία, meaning ‘a looking at, viewing, beholding’, and refers to contemplation or speculation, as opposed to action. Theory is especially often contrasted to ‘practice’ (Greek praxis, πράξις) an Aristotelian concept which is used in a broad way to refer to any thing done for the sake of any action, in contrast with theory, which is not.’

(Wikipedia, 2011)

So, with this definition in mind, historically the term ‘theory’ refers to contemplation or speculation. Interestingly those terms don’t have the same power as the term ‘theory’ – imagine Freud’s speculation about the unconscious or Rogers’ contemplation on the therapeutic core conditions. Terms suffixed with the word theory tend to have some gravitas but, in our view, should be treated with some caution. From our perspective, theories should be utilised as tools for understanding rather than the viewed as the truth within psychological disciplines.

*Experience without theory is blind, but theory without experience is mere intellectual play.*

(Attributed to Immanuel Kant)
So, ‘What is a good theory?’ Let’s turn to Charlie Brown (the comic book character) for an answer:

**Lucy:** ‘I’ve just come up with the perfect theory. It’s my theory that Beethoven would have written even better music if he had been married!’

**Schroeder:** ‘What’s so perfect about that theory?’

**Lucy:** ‘It can’t be proved one way or the other.’

(Schultz, 1976)

Unfortunately for Lucy, Karl Popper, the eminent philosopher, would challenge this sentiment. It was his view that a theory should be considered scientific if, and only if, it is falsifiable (Popper, 1963), and such a view is often reported as a litmus test within theory development. The human, within theory development, then complicates things further. Habermas notes that:

‘No science will relieve common sense, even if scientifically informed, of the task of forming a judgement.’ (2003, p.108)

Such a sentiment proves an interesting one to reflect upon when considering the development of the Increasing Access to Psychological Therapies project – clearly it is directed by research, however, for some (at least), the way in which it has been implemented seems to be one step removed from common sense. Even closer to home, it provides much food for thought about the way in which counselling psychologists use the term ‘scientist-practitioner’. How do we make judgements based upon theory when prizing such an approach? Counselling psychologists could easily be accused of wanting to have their cake and eat it when valuing intersubjectivity on the one hand and yet playing the evidence-based practice card with the other. Thus theory, and theory that is generated through research, is often used pragmatically by psychologists, but it is judgement and ethics that underpin its appropriate usage.

In contemplating the above sentiments it is clear that defining good theory is not an easy task. It could, therefore, be argued that we have relationships with theories. There will be some that we automatically gravitate to and those that feel as if they push us away (or we just outright reject). There will also be those that fit one day, but not the next. There is something of a paradox in being subjective entities assessing what theory can and cannot be generalised to others, however this is an ever increasingly important endeavour that seems understandable given budgetary constraints within the real world. One thing we can do to work within these systems is to heighten our own awareness to the prejudices that we hold towards the theories of others. Within Mick Cooper and John McLeod’s text entitled *Pluralistic Counselling and Psychotherapy* (2011 – also see the book review later in this publication), one of the first activities noted encourages the reader to consider their automatic liking or disliking of different therapeutic approaches. Invariably when conducted as a group activity, opinions differ greatly and once discussed there is usually some concession as to the utility of all approaches. It is then possible to situate that thinking within a theoretical perspective – all hail the dodo bird verdict and common factors theory (e.g. Luborsky, Singer & Luborsky, 1975; Cooper, 2008). Provocatively we could, therefore, suggest that the prevalence of theory in today’s society now means that theory itself has become meaningless – but that would be a theory itself and we would have to discount it. When considering how therapists actually use theory, John McLeod, in a different text, identifies the following ways:

- Something to hang onto: structure in the face of chaos.
- Offering the client a way of making sense.
- Constructing a case formulation.
- Establishing professional status.
- Providing a framework for research.
- The creation of knowledge communities.

(summarised from McLeod, 2010)

There is not enough space to elaborate upon these points here, and for the interested reader we advise going directly to the source for a very rich and enjoyable chapter. The
points do, however, highlight some of the multitude of ways that theory can be useful to the work that we undertake.

**Overview of this edition**
The selected contributors to this Special Edition of *Counselling Psychology Review* have taken a wide-ranging approach to theory. The papers are briefly introduced in turn below.

Borrowing from McLeod’s list above, theory in the context of the discipline of counselling psychology is perhaps most pertinent in terms of establishing the professional status of the discipline. However, Moller has argued in a piece that may be controversial for some, that the theory that underpins how British counselling psychology self-identifies needs a radical overhaul. Moller’s argument is that given the current context, the stated theoretical foundations of British counselling psychology, namely phenomenology and humanism, are parochial, rigid and irrelevant. Further that an alternative is to theoretically align counselling psychology with a commitment to diversity and multiculturalism, something which, she argues, would create a hugely socially relevant professional identity that also links British counselling psychology to counselling psychology elsewhere.

Counselling psychology has long (some might say frustrating) interest in interrogating its own identity. Another long-standing focus of attention has been diagnosis. However, the paper by Edge and West argues that the current coalition government’s focus on ‘The Big Society’ provides a unique opportunity to question the use of diagnosis in the mental health arena. The Big Society agenda is about increasing the role of communities and individuals in managing their health and well-being and this paper argues that one way to meet this call for action is to work towards community-based responses to human suffering that negate the need for diagnostic categories.

The Edge and West paper might be an example of a use of theory to create new ways of formulating client difficulties. A very different example of theory that speaks to this same purpose is Simm’s paper on case formulation from a person-centred perspective. The paper focuses on the tension between the professional competence requirement for counselling psychologists to formulate client issues within a chosen theoretical model and the abjuration of formulation in person-centred therapy. In doing so, it argues that it is possible to engage in case formulation from within a person-centred perspective if the process is collaborative or, to put it another way, client-centred.

Diagnosis and formulation are familiar concerns in the discipline; arguably integration is a more recent focus. Integrative theories of working with clients seek to provide platforms from which to formulate or otherwise make sense of client difficulties; they also of course often have an important goal of bringing knowledge communities together. This Special Edition offers two papers on the topic. The paper by Cutts begins by reviewing the theoretical and empirical support for integration of models of therapy, and then argues that before integration is attempted the goal of integration needs to be clarified, because while some approaches to integration are driven by a wish to create a unified single theory, others are not. Cutts then uses Egan’s model of the skilled helper as a problematic example of a model in which implicit theoretical assumptions about the integrative nature of the model are not made explicit.

A different approach to integration is taken by Walsh and Frankland, who present an integrative model in which they have blended Rogers’ person-centred and Beck’s cognitive therapy, cognitive relational therapy. The authors enumerate seven points of intersection between the two therapeutic approaches that together, they state, create an integrated meta-theory of therapeutic change. This common model does not mean a prescribed way of working but supposes that it would be possible to work with a client sometimes cognitively, and sometimes from a person-centred perspective, but always with...
the recognition of the centrality of the therapeutic relationship ‘as a crucible of change’.

The last two papers in this Special Edition focus on one particular integrative approach that is gaining a great deal of attention currently: mindfulness-based approaches. The ascendancy of mindfulness has been aided by the accumulating empirical base, which provides an example of theory providing a framework for research. Thus Bhanji’s paper focuses on the empirical evidence base for three of these third wave therapies in terms of their efficacy for clients presenting with depression: mindfulness-based cognitive therapy, metacognitive therapy, and acceptance and commitment therapy. The paper is cautiously optimistic about the evidence base to date, while arguing for the need for additional research.

The last paper in the Special Edition considers whether mindfulness-based approaches are a useful treatment modality for individuals with myalgic encephalomyelitis or chronic fatigue syndrome (ME/CSF). The paper by Dayes provides an example of a new theory (that mindfulness offers a useful approach for ME/CSF) which offers both practitioners and clients some hope in the face of what is a disabling, often mystifying and typically difficult to treat condition. Thus Dayes cites research that shows that mindfulness-based treatments have positively impacted one of the classic symptoms of the condition, fatigue. In addition to offering ‘structure in the face of chaos’, Dayes’ contribution offers the potential for a new research focus and for new theory building around what is a controversial neurological illness.

**Pulling it all together**

In contemplating the activity noted earlier in this editorial, in which individuals are invited to reflect upon their automatic responses to therapeutic approaches, we invite you to undertake a similar activity. Whilst reading through this Special Edition, take a moment to notice your responses to the contributions. ‘Do you agree or disagree with them?’ and importantly, ‘Where you do not agree, can you see utility within the theoretical ideas expressed?’ We hope that such a dialogue with the papers proves useful and through provoking. Along a similar line, we also provide two book reviews within this edition that will hopefully provide useful insights into further resources. First Amy Dodd reflects upon reading *Living with Voices: 50 Stories of Recovery*, and secondly, Clare Lennie shares a little too much of herself whilst reflecting upon the book *Pluralistic Counselling and Psychotherapy*. Skip to the end to find out more.

Finally, before moving on to the main body of this Special Edition it is necessary to say thank you to Lynne Jordan who has decided to take a step back from her role on the Editorial Board of *Counselling Psychology Review*. As with all members on this Board, her contribution has been invaluable and greatly appreciated over the past years.

**About the Editors**

**Naomi Moller** is Associate Head of Department and Subject Lead for Counselling and Health, in the Department of Psychology at The University of the West of England, Bristol. She is training representative for the Division of Counselling Psychology.

**Terry Hanley** is joint programme Director of the Doctorate in Counselling Psychology at the University of Manchester. He is the research lead for the Division of Counselling Psychology and is the regular Editor of *Counselling Psychology Review*.

**Correspondence**

**Terry Hanley**

Lecturer in Counselling Psychology and Editor of *Counselling Psychology Review*, Educational Support & Inclusion, Ellen Wilkinson Building, The University of Manchester, Oxford Road, Manchester M13 9PL.
Tel +44(0)161 275 8815
Email: terry.hanley@manchester.ac.uk
References


Upcoming CPD workshops

13 September  Supervision skills for Counselling Psychologists 2
Dr Linda Charles, CPsychol

30 September  Working with distressing psychosis: The challenge of developing meaningful therapeutic outcomes
Dr Alison McGourty, CPsychol

4 October  Through the eye of the trauma storm: EMDR in the treatment of trauma
Alexandra Richman, CPsychol

28 October  An experiential day: Introduction to Acceptance and Commitment Therapy (ACT)
Martin Wilks, CPsychol

25 November  MBCT: Clinical applications for anxiety and depression
Lisa Harrison, CPsychol

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The identity of counselling psychology in Britain is parochial, rigid and irrelevant but diversity offers a solution

Naomi Moller

Content and Focus: The identity of counselling psychology in Britain has been described as nebulous and vague; this paper takes a provocative stance designed to initiate debate and goes quite a bit further in its critique. Beginning with an outline of how counselling psychology in Britain self-describes, the paper draws on research findings and practice examples to argue that counselling psychology in Britain has an overly rigid and often irrelevant identification with phenomenology and humanistic values. Next the paper explores the identity of counselling psychology in other countries to make two points; first, that there is actually more than one identity for the discipline and, second, that British counselling psychology is disappointingly insular in outlook. Lastly the paper outlines the commitment to diversity and multiculturalism which is becoming the defining feature of American counselling psychology.

Conclusions: The paper concludes by arguing that a serious commitment to the agenda of diversity would create: (1) a strong platform for the type of critiques of mainstream psychology which British counselling psychology has historically engaged in; (2) a socially important research focus for the discipline; and (3) a special expertise in working with diverse others which would be hugely advantageous in terms of employability. More important, a commitment to this agenda would actually matter in a real world way.

Keywords: counselling psychology; identity; diversity; multiculturalism.

This paper provocatively argues that counselling psychology in Britain is parochial in outlook and has an overly rigid and often irrelevant identification with phenomenology and humanistic values. It is argued that a more promising and socially relevant identity for the discipline could be created if the identity embraced a commitment to diversity.

The identity of counselling psychology in Britain

In order to dispute the identity of counselling psychology in Britain it is first necessary to outline that identity. Unlike the Division of Clinical Psychology, the British Psychological Society’s Division of Counselling Psychology (DCoP) does not have a downloadable-by-the-public document outlining The Core Purpose and Philosophy of the Profession (DCP, 2001). However, if one is looking for an ‘official line’ on the core philosophy of counselling psychology in Britain, two sources seem apposite: the Divisional website and the Handbook of Counselling Psychology.

The Divisional website (DCoP, 2011) includes a page briefly detailing the history of the division; this credits the influence of ‘human science research’, psychotherapy and counselling traditions and practices, including those outside academia, a ‘phenomenological model of practice and enquiry’ and a value base ‘grounded in the primacy of the counselling/psychotherapeutic relationship’ as all being influential in the origins of counselling psychology. There is also a reference to the challenges that arise from the tensions between phenomenology and what is termed ‘the dominant conceptions of scientific psychology’. A second web page details ‘A Brief History of the Philos-
ophy of Counselling Psychology in the United Kingdom’ and provides an overview from early Greek philosophers through Foucault, with mentions (among others) of Carl Rogers and Heidegger. However, the page is largely descriptive, with no clear articulation of a relationship between counselling psychology and any philosophical position.

The *Handbook of Counselling Psychology*, currently in its third edition (Woolfe et al., 2009), begins with a four-chapter section entitled ‘What is Counselling Psychology?;’ there is no comparable section in the second edition (Woolfe, Dryden & Strawbridge, 2003) which suggests a recent renewed focus on identity. This is interesting because the preface to the second edition (written by the editors) heralds the move away from an ‘obsessive’ and ‘introverted’ focus on the identity of counselling psychology as a positive step indicative of a maturing discipline (p.xvii). In other words, an ambivalent attitude to critical self-examination is revealed here, as well as a history of identity questioning. In any event, the first chapter of this 2009 section: ‘Counselling Psychology: Origins, Developments and Challenges’ (Strawbridge & Woolfe, 2009) outlines an identity for counselling psychology in Britain that is inherently critical of prevailing approaches and which is founded in phenomenology and humanistic approaches and committed to a central focus on the relationship.

Considering the sources outlined above, which are undoubtedly familiar to readers of *Counselling Psychology Review*, one can see two commonalities important for this discussion: a notion that counselling psychology in Britain has a philosophical base in phenomenology, and origins in the practice of counselling which itself is based in humanistic approaches and values. It is acknowledged that the foci identified could be contested; for example, Cooper (2009) trawled counselling psychology texts to identify six somewhat different ‘essential values’ of the discipline. Nonetheless, considering the identified core identity components, what is arguably missing – since this historically and currently is clearly also critical to the discipline – is explicit reference to the mainstream scientific psychology, with its commitment to natural science and positivist empiricism (Klein, 1997).

**Identity in terms of humanism and phenomenology – irrelevant and rigid?**

Scientific psychology is perhaps defined by its commitment to empirical research. Thus, in addition to citing the Divisional website and the *Counselling Psychology Handbook*, it seems appropriate to refer to the limited research that has explored the identity of counselling psychology in Britain. Beginning with the notion that ‘nebulous and vague are descriptors that could justifiably be applied to popular and diverse notions of counselling psychology,’ one set of researchers used focus groups with counselling psychology trainees to develop a framework definition of the discipline (Cross & Watts, 2002, p.293). Interestingly although there was an acknowledgement that the training and activities of a counselling psychologist trainee would be enormously impacted by the theoretical model(s) espoused, the trainees’ conceptualisation of what counselling psychology is did not mention humanism or phenomenology at all. In other words, these newly-emerging professionals apparently did not see these conceptual foundations of the discipline as relevant.

An alternative empirical approach to uncovering the identity of counselling psychology in Britain utilised discourse analysis to explore the construction of the discipline in articles published in the *Counselling Psychology Review* (Pugh & Coyle, 2000). This paper noted the way in which writers differentiated the identity of counselling psychology from other therapeutic professions (e.g. clinical psychology) partly in terms of its phenomenological base and value system. However, in its conclusion the paper, which explored the ways in which counselling psychology was constructed as

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*Counselling Psychology Review, Vol. 26, No. 2, June 2011*
similar as well as different from comparable professions, warned that the identity of the discipline as constructed had failed to carve out a unique practice niche for counselling psychology in the marketplace. In order to avoid being crowded out, the authors suggested: 'It may, therefore, be necessary to engage in the process of constructing a separate therapeutic space for counselling psychology in a new and purposeful way' (Pugh & Coyle, 2000, p.97). The authors seem to be suggesting that when considering identity in terms of employability, the discipline’s commitment to phenomenology was not relevant.

What about humanism? One can argue that the influence of phenomenology as a philosophy and a method on counselling psychology in Britain is felt primarily through humanism. This is because phenomenology has been hugely influential in the development of humanistic approaches to counselling and psychotherapy (Cain, 2001). Yet although counselling psychology in Britain has a humanistic value base counselling psychology trainees are not required to be competent in a humanistic model (BPS, 2009). The freedom for trainees and training programmes to select a core model is in contrast to clinical psychology in Britain which requires its trainees to be competent in two approaches, one of which must be cognitive behavioural therapy (DCP, 2001). Nonetheless, the fact that the discipline’s identity is defined as it does require counselling psychologists to integrate a humanistic value set, even if that may be at odds with their dominant (e.g. psychodynamic or CBT) mode of client work. In addition, the values of humanistic approaches to counselling and psychotherapy have led to a distaste for some elements of positivist approaches to psychological distress such as diagnosis (Stiles, 2001), formulation (Johnstone & Dallos, 2006), assessment (Sequira & Van Scoyoc, 2002) and manualised treatments (Johnson & Boisvert, 2001) which can be tricky to bridge in client work, particularly in some settings (e.g. the British National Health Service [NHS]). In other words, it could be argued that the fact that British counselling psychology identifies itself with a humanistic value base creates difficulties for counselling psychology practitioners who work in settings where the value base is different (potentially the NHS) or who themselves espouse a therapeutic model which does not mesh easily with humanistic values. Yet tensions between professional identity and the way and place of working with clients could be easily avoided if the rigid insistence on a humanistic value base was abandoned.

In addition to impacting practice, the philosophical roots of phenomenology have also been associated with a preference in humanistic psychologists for ideographic, phenomenological and human science methods of psychological inquiry over the empirical paradigms derived from the natural science/positivist approaches (Cain, 2001). The value of this approach to research does not need to be outlined here; having said this, if a commitment to a phenomenological position creates a corollary rejection of positive methodologies and approaches to research this also can create tensions. To exemplify this, one only needs to think about the position of counselling psychologists who work in settings such as IAPT (Increasing Access to Psychological Therapies) services where there is a focus on ‘evidence-based practice’, NICE guidelines derived from randomised controlled studies, diagnosis and the use of psychometric assessments at every counselling session. In this context a rigid cleaving to a phenomenological value base is clearly uncomfortable. One solution is to say that counselling psychologists should not seek work in possibly the only expanding therapeutic arena of the moment. The other solution has already been suggested.

To this point, the focus has been on critiquing two core aspects of the identity of counselling psychology in Britain, namely humanism and phenomenology. Yet criticism alone is not a way forward so the next
section of the paper will focus on potential new ways of identifying counselling psychology in Britain, doing so by exploring how the discipline self-identifies outside of Britain.

**British counselling psychology – a parochial identity?**

An alternative approach to identifying the identity of counselling psychology is to explore how the discipline is conceptualised elsewhere. A 2007 edition of *Applied Psychology: An International Review* examined the status of counselling psychology in 12 countries (none of them Britain) and attempted to create an internationally applicable definition of counselling psychology. The definition arrived at was: ‘Counselling psychology concentrates on the daily life adjustment issues faced by reasonably well-adjusted people, particularly as they cope with career transitions and personal development’ (Savicknas, 2007, p.182). The author is American and while this view of the discipline is in line with the way counselling psychology is characterised in the US, it obviously does not jibe with the characterisation on this side of the Atlantic.

This journal edition also includes an article on the state of counselling psychology in Israel, which reveals that recently an initiative to create a counselling psychology division in the Israel Psychological Association was blocked, the author surmises to protect the ‘guild status’ of the country’s clinical psychology division (Benjamin, 2007). This point is included here to underline the point made earlier that in addition to an explicit identity articulated in terms of a philosophical and value base, there is necessarily an implicit identity that is meaningful in terms of creating a clear professional identity, conveying suitable professional status and providing access to jobs. One could argue that this aspect of the identity of the discipline is in fact very important in Britain, even if discussions about equal access to NHS jobs have not typically been discussed in terms of being about the identity of the discipline.

The notion of an implicit identity is perhaps also illustrated through the case of counselling psychology in South Africa: multiple criticisms of the discipline have been identified in this country, most damningly, that there is little focus in counselling psychology writing in South Africa on the critical issues of race and racism, and that while historically the discipline has not been politically ‘neutral’ that at the current time there is a ‘studious avoidance of politics’ that the authors argue is a stance in itself (Watson & Fouche, 2007, p.156). In other words, it is possible to see from the South African example some of the ways in which the discipline of counselling psychology may covertly express the values/beliefs of a dominant culture and, by doing so, serve to block psychological inquiry in certain areas. This example also underlines that counselling psychology in Britain may also be implicitly conveying certain values by not focussing in its professed identity on issues around diversity.

The focus of this paper, however, is on the explicit rather than covert/implicit identity of the discipline. Because the history of counselling psychology is longest in that country, the identity of the discipline in the US is next explored.

While counselling psychology has had Divisional status in the British Psychological Society since 1994 (Pugh & Coyle, 2000), the American Psychological Association (APA) Division of Counselling and Guidance was formed in 1946, becoming the Division of Counselling Psychology in 1953 (Hanna & Bemak, 1997). Practitioner trainings in psychology have been at Doctoral level since 1944 (Munley et al., 2004) and today counselling psychology in the US has become defined by a typical six-year full-time doctoral training in contrast to the three-year and only comparatively recently doctoral training in Britain. Another important difference is that while the US training almost always follows a scientist-practitioner model, this has not been the case in Britain (Corrie & Callahan, 2000), where the
favoured model is that of the ‘reflexive practitioner’ (Woolfe, 2006). The chief implication of these differences is that there are important differences in identity, and hence philosophical stance and values, of the national disciplines. However, what is the identity of counselling psychology in the US?

There have long been debates about the identity of counselling psychology in the US (c.f. Anderson, 1965; Drum, 1987; Hage, 2003; Hanna & Bemak, 1997; Lent, 1990, Watkins, 1983), or, as one author put it, ‘perpetual agonising about our professional identity and definition,’ (Larson, 1982, p.830). However, US commentators have increasingly noticed a growing fusion of identity between clinical and counselling psychology (Tyler, 1992), for example, in terms of work roles (Neimeyer, Bowman & Stewart, 2001). There is also similarity of US trainings in clinical and counselling psychology, such that examination of the recruitment materials for the two types of programme has revealed few differences (Morgan & Cohen, 2008).

Despite this, there are those that argue that counselling psychology in the US has a unique identity (Goodyear et al., 2008). Tyler (1992), one of the first counselling psychologists in the US, references the non-medical, non-pathological, but rather developmental, and well-being-focused identity of US counselling psychology. Also important are the historical origins in the American vocational guidance movement, which has led to an emphasis in US counselling psychology on career counselling, as well as a life-span development perspective, a focus on working with typical or ‘normal’ range clients, and a concern with prevention and positive development or well-being (Munley et al., 2004). The Model Training Programme articulation of the philosophy of counselling psychology training programmes also includes a commitment to scientific and critical inquiry (Murdock et al., 1998) which includes an openness to alternative research paradigms and methodological diversity (Munley et al., 2004). More recently, the discipline has been additionally defined by a focus on the importance of recognising socio-cultural context leading to emphasis on multiculturalism and consideration of diversity and well as social advocacy (Fouad et al., 2004).

Summarising this section, it is clear that the identity of counselling psychology in Britain is markedly different from the US construction; the commitments to diversity, vocational/career counselling, and political advocacy, are absent, for example. And while commonalities do exist – i.e. the commitment to a focus on client well-being or strengths – nonetheless, the marked differences emphasise the fact that the British conceptualisation of the discipline is only one of several national conceptualisations. This is a point that bears underlining since when reading the British literature on the identity of the discipline one could sometimes be forgiven for thinking that there was no world outside Britain. One problem with insularity, however, is that it limits opportunities to learn from others. In this paper it is suggested that a lot could be learned by British counselling psychology from US counselling psychology’s self-identity in terms of diversity.

**Counselling psychology and an identity defined by a focus on diversity**

The focus on multiculturalism and diversity is articulated in the philosophy of counselling psychology in the US (see, for example, the American Psychological Association’s Counselling Psychology Division 17 web pages). It is also reflected in the Counselling Psychology Model Training Values Statement recently endorsed by three organisations central to the discipline of Counselling Psychology in the US (Council of Counselling Psychology Training Programs, Association of Counselling Center Training Agencies, and Society of Counselling Psychology, 2009). The statement lays out the values related to diversity that they expect both trainees and trainers to commit themselves to; the statement also clearly puts
the onus on the trainees and trainers to challenge any personal values that may lead to a prejudicial response to any client. Such an explicit articulation of a commitment to personal responsibility in regards to promoting non-discriminatory practice arguably was not part of British counselling psychology before the Health Professions Council regulation of practitioner psychologists in 2009 enshrined the requirement.

As Standard One of the Standards of Conduct, Performance and Ethics states, as a practitioner: ‘You must not allow your views about a service user’s sex, age, colour, race, disability, sexuality, social or economic status, lifestyle, culture, religion or beliefs to affect the way you treat them or the professional advice you give’ (HPC, 2008, p.8). However in the US this active, in the broadest sense political, stance with regard to diversity is additionally reflected in recent calls in the counselling psychology field for a commitment in the discipline to social justice, i.e. an action-orientated commitment to challenging social injustice in society (Speight & Vera, 2008). From all of this one can conclude that it appears that across the Atlantic counselling psychology is associated with a much more clearly articulated and arguably more serious commitment to valuing diversity and combating intolerance and prejudice than is currently evident here.

The focus on multiculturalism in US counselling psychology is not just articulated through value statements but is also reflected in the profession’s key journals. For example, a 2010 analysis of the content of the Journal of Counselling Psychology found that multiculturalism/diversity comprised the largest category of published research, 15 per cent of the total, up from seven per cent in 1999 and zero in 1974 (Buboltz, Deemer & Hoffman, 2010). A 2005 analysis of the content of seven journals in which counselling psychologists might most typically be expected to publish also indicated an increase in research in the area of diversity and concluded that this appeared to represent a shift in the identity of the discipline (Buboltz et al., 2005). The commitment to diversity is additionally evident in the publication in discipline journals of reviews of research in the field of multiculturalism (e.g. Edwards & Pederotti, 2008; Worthington, Soth-McNett & Moreno, 2007; Yoon, Langrehr & Ong, 2011). To date, and by contrast, British counselling psychology includes no similar research focus on issues of diversity.

The broad research focus on diversity in US counselling psychology has encompassed a critical look at counselling psychology training programmes; arguably this research provides a way to determine whether there is more than a lip-service focus on diversity in the group of trainers. Thus the diversity of training programme staff has been examined (Moradi & Neimeyer, 2005) to see if such programmes are indeed recruiting, retaining and promoting a multicultural staff; the authors’ conclusions are cautiously optimistic. The extent to which course curricula do in fact reflect a commitment to diversity has also been examined – see, for example, a paper exploring the extent to which multicultural courses incorporate a focus on competence and social justice training (Pieterse et al., 2009). Again, a similar line of self-reflective research is not apparent in the discipline in this country.

Apart from staff and curriculum, another potential index of a commitment to diversity is acceptances into training programmes. In Britain the Division of Clinical Psychology annually publishes data on who is applying to that profession, including information on sex, age and ethnicity (Clearing House, 2010). There is no comparable accumulation of statistics in counselling psychology in this country and while there may be a number of legitimate reasons for such, the lack of effort in collating this information is concerning. Some of this data is collated by the 67 American Psychological Association programmes and according to a 2010 report, 72 per cent of students were women and 29 per cent were ethnic or racial minorities (Norcross, Evans & Ellis, 2010). Notably
other indices of diversity (i.e. sexuality or disability) are not reported; nonetheless, it would be interesting to see if the number of ethnic or racial minority students in British programmes was anything close to a third and whether or not the number of men training was similar.

Diversity in the population of future professionals is obviously important, however, majority population trainees need also to be assessed at programme entry for evidence of capacity or perhaps willingness to sign on for the US discipline’s commitment to multicultural practice. The above mentioned Values Statement has been used to think about how this might be done in an American training context (Loewy, Juntunen & Duan, 2009) and it is argued here that British training programmes could benefit from a similar consideration.

Taken together this review suggests that the identity of counselling psychology in the US involves a strong commitment to valuing diversity and multiculturalism that is evidenced in the explicit discipline value statements, research foci, and commitment of training programmes in terms of staffing, students and curriculum. It is the argument of this paper that by contrast British counselling psychology is woefully and indeed shamefully lacking. The lack is hard to forgive since diversity is just as relevant in the increasingly multicultural society of Britain as it is in the US. Or one could put it even more provocatively and say that diversity matters in a real world way – unlike a dusty commitment to phenomenology.

Conclusions
Some influential counselling psychologists in the field of multiculturalism have argued that the identity of counselling psychology in the US was ‘saved’ by multiculturalism (Atkinson, Wampold & Worthington, 2007). Atkinson argued in this paper that the focus on multiculturalism that emerged in US counselling psychology in the 1980s prevented a de-facto merger into clinical psychology by providing an emphasis on normal versus abnormal development and a critical lens on individualised medical models of diagnosis and pathology as well as the application of ‘standardised’ treatments. It is the argument of this paper that British counselling psychology could be saved by multiculturalism too. First, a commitment to diversity could potentially give the discipline a very strong platform for the historical critique of diagnosis, psychometrics, standardised treatments and evidenced-based practice, because it is most specifically non-majority populations who do not fit these approaches. Second, a commitment to diversity could create for counselling psychology in this country a socially important research focus; for while in the US counselling psychology has led the way in creating a knowledge base around working with multicultural populations, much of the US literature of multicultural literature does not translate easily to Britain, given cultural differences, for example, in the history of immigration or how ethnic groups are identified/categorised. Third, an identity in terms of multiculturalism could create for British counselling psychology a special expertise in working with diverse others; in the current fraught economic climate this identity could have huge practical value in terms of employability. In sum, a central and committed identification with diversity and multiculturalism could create an identity for counselling psychology that was clear, socially relevant and responsive, and forward and outward looking, rather than parochial, rigid and irrelevant.

About the author
Dr. Naomi Moller
The University of the West of England.

Correspondence
Email: naomi.moller@uwe.ac.uk
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MENTAL HEALTH’ has long been a euphemism for ‘mental illness’. Hence we have ‘Mental Health Services’ which focus almost entirely on the management of mental illness. Indeed, the concept of recovery and adoption of a ‘recovery model’ is relatively new approach with which mental health professionals operating in a risk-based, predominantly ‘medical model’ of care still grapple. There are signs that the new political landscape offers opportunities for a significant shift in our thinking about what constitutes ‘mental health’ and how best to create the conditions that foster it. This will require not just a change in language to describe largely amorphous diagnostic categories but a ‘cultural’ shift among practitioners in terms of how they work and engage with individuals and communities. In this paper, we use the concept of ‘depression’ as a heuristic device for examining what this ‘cultural shift’ might look like in the context of the Government’s rallying call for all to engage in creating ‘The Big Society’.

Psychiatric diagnoses are notoriously unreliable. What constitutes mental health or illness is known to vary between practitioners, across cultures and over time. For example, in the 1950s and 1960s ‘schizoid’ was a relatively popular diagnosis. More recently, in the 1980s ‘personality disorder’ (a predominantly ‘male’ diagnostic label) was in vogue and in the 1990s ‘borderline personality disorder’ emerged as essentially a ‘women only’ category of psychiatric diagnosis.

Although apparently gaining widespread acceptance in both professional and lay discourse, ‘depression’ remains a highly contested concept. Those who espouse a biological basis for depression suggest that genetic or hormonal factors are responsible for onset (Scott & Kohen, 2000). From a psychological standpoint, depression is regarded as the result of already vulnerable individuals succumbing to stressors or depressogenic ‘triggers’ (Haw & Kohen 2001). From a social perspective, however, depression is believed to result from individuals’ response to adverse social and environmental agents such as: stressful life events, socioeconomic disadvantage and lack of interpersonal support (Brown & Harris, 1978; Nicolson, 1998; Oakley, 1980; O’Leary et al., 1997; Stanton et al., 1995).
However, despite its contested nature, ‘depression’ remains a very common diagnosis in Britain and elsewhere in the Western world. Indeed, so common is the diagnosis of that depression has been termed ‘the common cold of mental illness’ with as many as one-fifth of the UK population being said to experience depression at some time. Claims for the universality of the condition have been challenged by those who point out that the concept and language to describe it does not exist in many non-Western cultures (CRE, 1993). Where attempts have been made to quantify ‘depression’ in other cultures, the picture has been somewhat confusing. To illustrate, very low rates of depression are consistently reported among Chinese and Japanese people has been partially attributed to relatively high levels of social cohesion within these societies (Yoshida et al., 1999; Yamashita et al., 2000; Lee et al., 2001). However, such a stance might say more about the cultural stereotyping of other cultures rather than the lived realities of people in rural China, for example. Furthermore, studies in the US, the UK and elsewhere, consistently report low levels of depression among people of African descent (Williams et al., 2007; Kessler et al., 1994). Given that the supposed interrelationship between socio-economic deprivation, the relative social positioning of Black people in the US and the UK, and rates of depression; this presents something of a paradox which is surely worthy of further investigations. Curiously, the mechanisms that might explain why individuals do not succumb to ‘depression’ despite experiencing significantly levels of adversity and other ‘risk factors’ which are usually associated with onset, remains largely under-explored and under-theorised.

Nevertheless, as exemplified by Japanese and Chinese studies (Yoshida et al., 1999; Yamashita et al., 2000; Lee et al., 2001), screening and diagnostic tools are recalibrated thus resulting in increased levels of diagnosis within these populations. From a social constructionist perspective, this is not surprising. As Gergen (1996, 2001) reminds us; once a diagnostic category is devised, more and more people will be found to fit it and, of course, to be in need of treatment by the very people who conceptualised and co-constructed the condition in the first place. In this context, Gergen (1996) asserts that disease classification systems such the American Psychiatric Association’s Diagnostic and Statistical Manual for the Diagnosis of Mental Illness (DSM) are produced by communities of practitioners who, by and large, share a common world view. In consequence, the taxonomies they devise to describe, classify, and diagnose ‘mental disorder’ and ‘mental illness’ are not only signifiers of membership of ‘our club’ (which is necessarily exclusive); they are also the means by which these conditions are reinscribed and new ‘disorders’ are constructed (Gergen, 1996). As new ‘disorders’ are arrived at by consensus, this raises questions about the interplay of power, gender and other variables on what remains a largely Westernised, male-dominated approach. It will be interesting to see what new ‘diagnostic categories’ emerge from the process to develop DSM-V, which is due for publication in the near future.

Issues of power, dominance and gender have been central to the discourse on mental illness in general and ‘depression’ in particular (Busfield, 1996; Showalter, 1987). From its very inception, women have been twice as likely as men to be diagnosed with depression (Gelder et al., 1996). Debates about whether gender-related difference in rates of diagnosed depression are accurate reflections of psychological morbidity or artefacts reflecting differences in diagnostic systems and processes or gendered differences in attributional styles and help seeking behaviours is the subject of fierce debate (Cutrona, 1983; Wagner et al., 1998). To illustrate, it has been suggested that individuals seeking help who present their feelings using ‘psychologising’ attributional styles – that is, offering psychological explanations for their symptoms (mostly women) – are likely to receive psycho-
logical diagnoses. Those who adopt ‘normalising styles of attribution’ – using commonsensical overtones to explain away their symptoms, attributing them to environmental or physiological causes, (mostly men) are more likely to receive physical diagnoses (Kessler et al., 1999). These gendered presentations and the professional responses to them both increases women’s over-representation and men’s under-representation in depression epidemiology.

Accordingly, from the perspectives of feminists and antipsychiatrists, rather than being an accurate reflection of morbidity, the increased likelihood of women receiving psychiatric diagnoses reflects processes of labelling and the social construction of mental illness that can be understood only within historical and social contexts (Showalter, 1987; Nicolson, 1998). From this perspective, mental illness is, therefore, regarded not as something that exists within individuals but rather within the systems in which individual agents operate. Depression may, therefore, be regarded as a social role, which if more commonly ascribed to and internalised by women, renders them both more willing to self-label and to engage in the kinds of help-seeking behaviours which will increase the likelihood of receiving psychiatric labels. From this ideological standpoint, psychiatric labels may be regarded as mechanisms of social control. Women who fail to conform to their expected social roles (particularly those of nurturing and caring) are more likely to be regarded as deviant and their behaviour labelled as mental illness (Scheff & Heller, 1996). Furthermore, the transformation of social and emotional difficulties into mental illness and the individualisation of associated pathology not only masks social aetiology, it also reinforces notions of women’s passivity and helplessness and allows political forces to abnegate their responsibility to address social triggers of mental illness such as poverty; childhood abuse, neglect and trauma; and domestic violence (Busfield, 1996; Doyal, 1995; Graham, 1993). This has led some commentators to argue for the dismantling of cultural connections between women and madness.

These debates also highlight wider unease with the apparently unproblematic approach to ‘diagnosis and treatment’ by health professional of what many regard as the imposition of a medical model on what are often social processes. It could be argued that the prescription of medication and antidepressants in particular has replaced the dispensation of care and support in times of difficulty. Observations which led Pilgrim and Bentall (1999) to coin the phrase ‘medicalisation of misery’ in relation to medical approaches to managing depression.

**Responding to need**

‘The Big Society’, in the UK, is a key element of Government proposals both to reform public services and increase the roles and responsibilities of communities and individuals in managing their health and well-being. This approach to major reform and reconfiguration of services relies not only on devolution of centralised power but also on the mobilisation and promotion of what we call ‘below the radar’, community-based activities and organisations. This kind of activity is believed to foster empowerment and engagement of individual, which is central to creating community cohesion. ‘Below the radar’, therefore, refers to much more than formal/semi-formal activities and support provided by voluntary/‘Third Sector’ groups. It refers to the kind of ongoing, informal, mutual care and support – a ‘social economy’ – in which ‘social enterprises’ not only flourish but also present viable and sustainable alternatives to the welfare state (McCabe, 2010).

In this paper, whilst we take a critical stance on psychiatric diagnosis in general and depression in particular, this is not to deny the real suffering that people experience when they seek help that might result in psychiatric labelling. However, part of our concern is the extent to which such diagnostic labels hinder or facilitate the process of seeking and receiving appropriate help and support.
It is worth posing the question of why depression, anxiety and other mental health conditions are still being diagnosed in increasing number in Britain today (Wilkinson & Pickett, 2009). Although some of this increase could be due to changes in diagnostic procedures, evidence from many sources points to an increasingly less healthy society. Indeed Wilkinson and Pickett (2009) regard the growing inequity in British society as a major cause of psychological distress. They argue that providing expensive individualised treatment for what may well be collective or societal ‘illnesses’ is both ineffective and inefficient. They suggest that, ‘rather than requiring anti-anxiety drugs in the water supply or mass psychotherapy... reducing inequality would increase the well-being and quality of life for all of us’ (Wilkinson & Pickett, 2009, p.33).

Of course, if instead of focussing on the diagnostic labels, one begins to focus on the help people need, what is available, and how they choose to access it (or not); some interesting observations become apparent and different options for offering care and support begin to open up. Firstly, when given voice, people with conditions like depression often know that they need help and are able to identify the kind of help they want. This is where it is argued that being given a ‘serious enough’ diagnosis such as ‘postnatal depression’ can sometimes be useful in attracting suitable help in a timely manner (Elliott et al., 1994; Edge, 2005). However, we contend that the needs of a particular patient or client might be better met if commissioners and practitioners could recognise the web of professional and informal, community-based, ‘below the radar’ support systems currently available or which could be made available with support. This way of thinking would mean that we could begin to explore meaningfully issues such as: the gaps in care provision and pathways, how these gaps might be filled and what part the various levels of services (for example, statutory versus voluntary sector) could/should play in responding to needs in accessible and sustainable ways.

This perspective of therapists engaging with the local community around their place of work is not a new idea and such an approach is well articulated:

1. Within youth work – see, for example, Crimmens et al. (2004) which states that ‘street-based youth work with socially excluded young people does work, not always, not everywhere, but probably more effectively than any other method yet devised for reaching those socially excluded young people (p.70).

2. Community and voluntary work – ‘Frontier Camps and Boaz are examples of many small voluntary bodies – Christian and secular – which include the excluded. Amongst them are locally-run community projects in deprived areas which are often in the hands of poor people, the unemployed, lone mothers and others considered as low in society’s rankings’ (Holman, 2008, p.260).

However, professional engagement is not always positive. As Jordan points out, ‘social work’s roots in 19th century individualism leaves it particularly vulnerable to co-option’ into an agenda that relies on ‘coercive measures to discipline those who fail to makes the necessary or successful efforts on their own behalf’ (Jordan, 2004, p.5). On the other hand, many counselling psychologists, counsellors and psychotherapists are already in effect ‘community-based’ – working in National Health Service (NHS) clinics or voluntary settings. This could be deliberately developed and enhanced by linking up statutory organisations with locally based community workers, community organisers, voluntary groups and religious groups, which might result in therapeutic skills being put to use in the service of improving community mental health. McLeod (2009) talks about ‘embedded’ counselling, in which people draw on counselling skill as part of another role. Here we are talking about embedded counselling skill being a resource for community development and mental health.
If there is any useful truth in the rhetoric about ‘The Big Society’ it is precisely in this area. Dare we suggest that times spent at meetings be reduced so that time spent in the local community be increased? It is not enough for us professionals to know that such resources exist within the local community we actually need personal links to be in place. For example with regard to youth work ‘When you’ve worked in an area for some time, you get known and then you get trusted. This credibility extends beyond the young people you’ve actually worked with to the others in their networks, young people you’ve never met’ (Crimmens et al., 2004, p.5).

In this context the findings from Hedelin and Jonsson’s (2003) study of elderly women’s experience of mental health and depression assume greater significance. They found that when the women’s existence and value were confirmed their mental health improved and vice versa. They speak in terms of mutuality being a key feature of a healthy approach to treating depression. Clearly the scope for the impact of community groups on local mental health lies in their ability to value and affirm one another. It has echoes of Martin Buber (1970) proposition that we can treat one another as It and form ‘I/It’ relationships or as ‘Thou’ in ‘I-Thou’ relationships.

However, we should be careful not to claim too much for a careful acceptance and listening role with regard to mental health issues, In terms of our understanding of depression in particular, it is salutary to read from a Professor of Nursing with lived experience of depression that, ‘textbook accounts of depression never seemed, to me, to match what I was feeling. Neither have I much confidence in psychology. Psychology never seemed to be about my experience of life’ (Burnard, 2006, p.242).

**Conclusion**

In this paper we have suggested that collective ways exist or could be facilitated into existence as part of the response to ‘mental health epidemics’ such as the high prevalence of depression in the UK in the current context of cuts and ‘The Big Society’. We acknowledge that change would be necessary at the political level to bring about a more equal society which, from the experience of the past 12 years, cannot be achieved through stealth. It is our belief that a more healthy society would result from supporting and nurturing activities which enable individuals and communities to recognise and harness their capacity for health, healing and well-being. Almost anything that brings people together in a variety of ways such as religious groups, choirs, yoga classes, schools, youth and community centres have the potential to enhance health. The more healthcare can be linked to such groups the better. However, unless such approaches are undertaken with appropriate levels of investment and support (including measures to reduce social exclusion and disadvantage); they can rapidly become ‘deficit models’ where deprived communities are blamed for lacking the wherewithal to become ‘resilient communities’. This would mean that, instead of becoming part of ‘The Big Society’; such communities and the individuals within them would be further stigmatised to the detriment not only of their well-being but that of the whole population to which they belong.

**About the Authors**

**Dr Dawn Edge**, Research Fellow, School of Community-Based Medicine, University of Manchester.

**Dr William West**, Reader in Counselling Studies, School of Education, University of Manchester.

**Correspondence**

**Dr William West**
School of Education, University of Manchester, Oxford Road, Manchester M13 9PL.
Tel: 0161 275 3397/Fax: 0161 275 3548
Email: william.west@manchester.ac.uk
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COUNSELLING psychologists engaged in clinical practice need to be able to formulate their clients’ presenting issue(s) within their chosen therapeutic model. This is a skill that is highlighted in the Core Competencies Counselling Psychology Guidance for Counselling Psychology Programmes devised by the British Psychological Society (2010) whereby it is stipulated that practitioners should be able to carry out psychological assessments and make formulations of a variety of presentations. In particular, to be able to ‘formulate clients’ concerns within the specifically chosen therapeutic model(s)’ (p.15). This is also outlined in the Standards of Proficiency – Practitioner Psychologists laid down by the Health Professions Council (HPC, 2009). Therefore, being able to formulate the client’s presenting concerns irrespective of which theoretical model is embraced by the practitioner, is deemed a professional requirement, a hallmark of clinical competency and regarded as fundamental to routine clinical practice (Eells, Kendjelic & Lucas, 1998).

Despite this, it is recognised that case formulation, irrespective of therapeutic modality, is often an ‘undertaken and underlearned clinical skill’ (Sim, Gwee & Bateman, 2005, p.290). This highlights the importance of understanding the role of case formulation both generally and specifically. Whilst it is recognised that formulation has been a somewhat neglected area, recent years have witnessed an increased interest in the topic in psychology, psychotherapy, counselling and psychiatry, in particular in areas such as research and training (Johnstone & Dallos, 2006). It seems, therefore, timely to examine this construct and the role it has to play for counselling psychologists engaged in clinical practice, especially those who work within a person-centred theoretical framework, as traditionally case formulation has been explicitly rejected within this approach (Rogers, 1951).

What is a psychological case formulation?
Before going on to discuss the role of case formulation within a person-centred frame-
work, a definition is firstly necessary. A working definition provided by Sim et al. (2005, p.290) states:

‘A case formulation summarise the salient features of the case in a nutshell and identifies important issues quickly, particularly complex cases with multiple problems... helps to organise and integrate the clinical data around a linchpin and allows the clinician to focus on the heart of the matter in each individual case.’

Thus, it is a method by which both client and therapist can try to make sense of the processes that have led to the client’s particular difficulties in terms of how they began, what factors are maintaining them, and whether these are internal or external to the client, or both. For example, particular thinking patterns, negative life events, emotional and behavioural reactions. Typically it is an explanatory working hypothesis driven by the underlying theory and in addition to providing an understanding of the client’s difficulties, it influences the direction, course and outcome of the therapeutic process (Bennett, 2003). Thus, it can serve as a blueprint or map in guiding therapy, and act as a marker for change (Eells, 2007).

Whilst there are many definitions of case formulation, most cover the same areas: the descriptive, prescriptive and predictive aspects of the client’s presenting problems (Sim, Gwee & Bateman, 2005). However, there are further functions which include facilitating therapist empathy and development of an internal supervisor, identification of potential ruptures in the therapeutic alliance and generally, enhance communication with the client (Butler, 1998; Eells, 2007). Thus, this ‘process and function’ aspect (Blackburn, James & Flitcroft, 2006) highlights that implementing case formulation within routine clinical practice is a relational activity involving both client and therapist. That is, as Blackburn, James and Flitcroft (2006, p.126) assert, it is a ‘shared process and heavily dependent on feedback’ from the client.

Varieties of case formulation

With many theoretical models the ability to formulate or understand the client’s difficulties is a fundamental feature of the therapeutic process. For example, in Cognitive Behaviour Therapy (CBT) it is a core clinical skill and a key feature of the therapy. A formulation within this therapeutic modality includes current problems the client experiences and attempts to draw together faulty thinking patterns and structures, problematic behaviour and the interrelationship between these and the client’s emotional response. It also considers environmental and biological features that may interact that can act to predispose, precipitate and maintain the individual client’s difficulties. The aim is to draw together the presenting difficulties and how they relate to one another in a coherent framework, offer an explanation of how such difficulties emerged and to attain a mutual understanding of how the client’s difficulties are understood and made meaningful to him or her (Johnstone & Dallos, 2006).

Interpersonal Psychotherapy (IPT) is also formulation driven in its approach to understanding client distress. In this model, symptoms, usually depression, are understood within the interpersonal context. An interpersonal formulation is embedded within a biopsychosocial model (Weissman, Markowitz & Klerman, 2000). Biological diatheses combined with early life experiences and attachment style can render the individual vulnerable to develop interpersonal difficulties in times of crisis when social support provision is lacking or perceived inadequate. In IPT practice all these elements are drawn together to formulate an understanding of the client’s presenting issues within a particular focal area: role disputes, grief, interpersonal sensitivities and role transitions (Stuart & Robertson, 2003).

In psychodynamic psychotherapy, case formulation is utilised as a means by which the client’s difficulties may be understood in terms of repeated maladaptive patterns occurring in relationships (Leiper, 2006).
Presenting problems are regarded as being manifestations of underlying conflicts most likely rooted in early childhood. Therapist feelings are utilised to develop the formulation of the client’s issues (Sturmey, 2009).

In Systemic Therapy the role of case formulation is to assist ‘identification of what is seen as the problem and the ways in which it is linked to difficulties which the family has attempted to overcome’ (Dallos & Stedmon, 2006, p.73). A case formulation within a Systemic framework includes deconstruction of the problem, identification of problem-maintaining patterns and feedback loops, beliefs and expectations, transitions, emotions and attachments, as well as contextual variables (Dallos & Stedmon, 2006). Thus the focus is upon understanding psychological problems within a social, political context and the interaction between people (whether family or colleagues), with consideration given to recognition of problems occurring at various developmental stages.

In an integrative model such as Cognitive Analytic Therapy (Ryle, 1995), emphasis is placed upon a reformulation of the clients difficulties which is achieved by identifying patterns of roles and procedures such as beliefs, thoughts, feelings and actions within ‘the context of a dialogical view of human relations and individual consciousness’ and this may be drawn up in a flowchart style showing the relationship between all the different components and summarised in a letter to the client (Eells, 2009, p.303).

Within the humanistic paradigm however, in particular in the Person Centred approach, the concept of case formulation and the idea of including it explicitly during the therapeutic process has been consistently rejected (Johnstone & Dallos, 2006; Eells, 2007). Rogers (1951) held the view that it created a power imbalance within the therapeutic relationship by positioning the therapist in the role of an expert and consequently, had the potential to create an unhealthy dependency as the client will defer to the therapist’s understanding, resulting in the protraction of formation of a genuine relationship. As a result, Rogers (1951) contended that it had the potential to cause harm. As Johnstone (2006, p.216) points out:

‘The fundamental issue here is power, and specifically, the power of one person, in an expert position, to impose their viewpoint on another.’

Indeed, research in the area provides accounts of when case formulation has been detrimental to client wellbeing. In a study carried out by Chadwick, Williams & Mackenzie (2003) exploring the impact of case formulation on anxiety and depression, accounts from participants revealed that some found it upsetting, worrying and even made them feel sad. It would seem that pulling together all the information of the client’s presenting issues can present a somewhat overwhelming picture which may make them feel despondent. Further research in the area shows that it can have other effects on the client such as making them feel as though they cannot trust themselves (Proctor, 2002), as it has the potential to be laden with therapist judgement and interpretation (Masson, 1990). Therefore, Roger’s (1951) view then that it has the potential to create a power imbalance in the therapeutic relationship is indeed valid if we are to consider the above although somewhat limited research in the area, showing it has the potential to be harmful to clients.

The utility of case formulation
Taking this further, Johnstone (2006) outlines the various controversies and debates concerning case formulation and asks questions such as: to whom is it useful for? Is it harmful? Do we actually need it at all? Can anyone do it or is everyone already doing it? Is it too individualising? Where does it sit in relation to diagnosis? Drawing together research in the area Johnstone (2006) shows that on the one hand it can be unhelpful for clients as outlined above, which is echoed by Butler (1998) who states that it can seem like clients are being
'weighed up, evaluated, or judged – like being ‘seen through’ or ‘rumbled' rather than understood.' Furthermore, there is little evidence to show that it has an impact on client outcome (Madill et al., 2001; Chadwick et al, 2003). The individualising nature of it has also been criticised as it fails to take into consideration personal, political and social contexts (Johnstone, 2006).

However, caution is warranted because as Johnstone (2006) points out there is little experimental evidence to support these claims and, therefore, results from existing studies must be interpreted with caution. Despite this case formulation is regarded as a basic clinical skill that many health professionals are expected to acquire during training and engage in routinely in practice, is included across many professional training contexts, and as outlined at the beginning, many professional bodies stipulate that it is a sign of professional competence (Sturmey, 2009).

Given these conflicting views, is there anything useful about employing case formulation during routine clinical practice? From the point of view of the therapist it is deemed beneficial in that it helps the therapist make sense of the client's difficulties, organise and synthesise information, identify risks, choose the appropriate intervention and where endorsed by the client elicit feelings of hope about the therapy, contribute a greater sense of alliance, collaboration, confidence within the therapist in the approach taken and adherence to it (Chadwick et al., 2003). Yet, what about the client? Certainly clients do not walk through the door of the therapy room requesting a case formulation (Johnstone, 2006). Of course, clients do come to therapy to gain insight, understanding and help in dealing with their difficulties. Roy-Choudry (2003) points out that the fundamental feature of all therapy, regardless of theoretical approach, is to seek to understand the client and make sense of their unique experience and to offer up to them an understanding of their difficulties, based on what they have told us, in a tentative and provisional manner. Case formulation is ultimately about understanding and thus a means by which the client can ‘make sense of the apparently senseless’ (Blackburn, James & Flitcroft (2006, p.126). It is about helping the client make sense of their difficulties and associated distress and facilitate the process by which they can construct meaning from their experiences (Johnstone, 2006).

There are wider issues also to be considered such as the reality of limited resources, the increasingly limitless need for psychological therapy, shortfalls in funding of services, all of which have led to many therapists finding themselves having to work within a time limited framework. As a consequence many are frequently finding themselves having to work more efficiently and to justify the value and expense of their input (Eells et al., 1998; Tudor, 1998). According to Eells et al. (1998) this highlights the importance of implementing case formulation as it can help the practitioner to organise and synthesise the material succinctly (Sim et al., 2005) making it appealing for those restricted to time limited service provision.

Despite the criticisms levelled against it, it seems everyone is in the process of formulating whether about the world, other people and one self (Johnstone, 2006). If this is the case then all therapists, irrespective of theoretical persuasion are engaging in case formulation. According to Johnstone (2006, p.228) this means that even therapeutic modalities that explicitly reject case formulation are ‘…in fact using techniques or strategies which have the aim of helping clients reach a psychological understanding, or formulation, of their distress. The key difference seems to be an overriding emphasis on respecting the client's own views.’ This, the author contends is a ‘welcome antidote to some of the abuse’ that other theoretical approaches have been guilty of and which the idea of case formulation has been criticised, and why person-centred practitioners have been reluctant to engage in it.

Recent writings in the area of case formu-
lation do highlight the collaborative nature of it and the positive impact it can have on both client and therapist alike. For example, in the Chadwick et al. (2003) study, many participants reported that case formulation was useful in that it increased their self understanding, and that they felt reassured and encouraged by it (Johnstone, 2006). In the same study therapists reported feeling validated when clients endorse a case formulation, that it helped them feel more optimistic about potential benefits of therapy for the client, and increased the therapeutic alliance, collaboration and adherence to the chosen theoretical approach, and generally provided a greater understanding into their clients’ difficulties. In a study carried out by Evans and Parry (1996) exploring the impact of the reformulation letter in Cognitive Analytic Therapy (CAT), it was found that that clients felt that the therapist had really listened to them and understood them. As stated, research is limited and as such it is an area ripe for investigation by researchers. It is important to note, as Johnstone (2006, p.230) points out: ‘The potential criticisms and limitations of formulations echo the potential criticisms and limitations of therapy itself.’

Another area where case formulation has been deemed useful is in the role it plays in offering an alternative to diagnosis as it provides a personally meaningful account of the individual’s difficulties (Boyle, 2001). This is contrary to Rogers’ (1951) views whereby he regarded formulation as ‘psychological diagnosis.’ This is where the confusion may exist within the person-centred arena as the idea of case formulation as Rogers (1951) viewed it was something that led to a formulation of a treatment plan as a result of assessment and diagnosis. This is also a view which more contemporary theorists uphold (Mearns, 1997). Gillon (2007) writes briefly about formulation within person-centred therapy and contemporary practice in mental health and states that it is: ‘... inherently diagnostic in prioritising therapists’ knowledge and expertise over the client... is a process by which, although conducted as mutually as possible, draws heavily on psychological theory in understanding a client’s difficulties, thus detracting from the client’s own experiencing and perceptions in favour of the knowledge of the therapist.’

Yet, Gillon (2007) does not completely reject the idea but rather suggest that when considering formulation within a person-centred framework what matters most is the ‘formulation’ that the client shares with the therapist. These views are not dissimilar to Tarrier (2006) who contends that case formulation, in particular if it is to be effective, must be a collaborative endeavour, comprise the clients views and beliefs, and not be imposed upon him or her as this would indicate it is coming from the therapist’s frame of reference. So, is there a middle ground for counselling psychologists whereby implementation of case formulation within a person-centred framework can be achieved?

**The role of case formulation in person-centred practice: Is there one?**

Recent developments within person-centred theory and practice regarding the role and utility of assessment and diagnosis may help answer this question (Wilkins, 2006). Assessment and diagnosis are typically associated with the medical model and have consistently been rejected by person-centred practitioners (Mearns, 1997). And as stated, the role of formulation has been consistently aligned with both and as such has been rejected as it has in a sense been guilty by association.

It is important to point out the distinct differences between these concepts. Assessment refers to a history taking process that typically entails gathering information on the client’s presenting problem(s) and background factors that have led to the onset of the difficulties. It may involve objective tests and measures (Joseph & Linley, 2006). Essentially it is the first stage of case formulation as the information gathered enables the practitioners to form an understanding
of the client’s issues. Diagnosis refers to the labelling or categorisation of the difficulties gleaned from the assessment and formulation process and is usually framed within a medical model. A number of writers acknowledge the need for practitioners, especially those working within mental healthcare systems, to be open to the idea of assessment and diagnosis (Bozarth, 1998; Stiles, 2001; Wilkins & Gill, 2003; Wilkins, 2006). In fact Rogers (1957) himself is noted as having acknowledged the utility of diagnosis regarding the therapeutic relationship as it can increase understanding of the client’s difficulties which consequently can enhance empathy and congruence (Berghofer, 1996; Binder & Binder, 1991; Schmid, 1992). Both Sommerbeck (2007) and Gibbard (2008) write about the challenges of working within the psychiatric and NHS systems as person-centred practitioners but at the same time show that it is possible to align person-centred theory and practice within an arena that has traditionally been criticised as being dehumanising.

However, assessment and formulation do not necessarily lead to diagnosis and it is acceptable to carry out both without diagnosing the client. Joseph and Linley (2006) point out how person-centred practitioners do not routinely engage in taking case histories, assessing, formulating or diagnosing clients. However, they do acknowledge that client-centred therapists differ in the extent to which they deem such activities necessary. It is somewhat of a myth to assume that all person-centred practitioners are totally opposed to assessment and diagnosis (Wilkins, 2006). However, counselling psychologists differ somewhat from other person-centred practitioners in that a hallmark of clinic competency is that they are required to be able to carry out psychological assessment and formulate client presenting problems within their chosen theoretical model and this includes those who espouse a person-centred framework. Therefore, it is important that they find a way of upholding the requirements of their professional guidelines and at the same time value and respect the philosophical basis of the person-centred theoretical model.

Many counselling psychologists working within the NHS system are familiar with the challenges of offering time-limited therapy, that is evidence based, is cost-effective, demonstrates efficiency, outcomes and results (Tudor, 2008; Gibbard, 2008). And for those who espouse a person-centred approach to their clinical practice, these challenges are even greater. Yet, it is possible to carry out person-centred therapy within an arena that is dominated by the medical model. Embracing concepts such as assessment, diagnosis and case formulation does not necessarily mean abandoning a person-centred practice. What is required is careful consideration to the ‘how’ the therapy is conducted.

**Integrating theory and practice**

According to Sim et al. (2005) case formulation rests at the point where etiology and description, science and art, theory and practice intersect. With this in mind how then does a counselling psychologist working within a person-centred framework blend these elements in order to introduce and implement a case formulation to their client, without losing the very essence of the therapy and practice which emphasises the imperative of remaining within the client’s internal frame of reference? This is not an easy task and requires a great deal of sensitivity, timing, understanding and confidence in oneself and the theory. Therapy, according to Wilkins, is a dyad, or in referring to Schmid (2003), he asserts that it is about ‘we’ and thus, the person-centred relationship ‘is and must be co-operative, collaborative, co-created and co-experienced.’ The information gathered from the client via assessment and formulated into an understanding which can be shared and clarified with the client may help to ensure that the relationship remains ‘co-created’ and ‘co-experienced.’ Indeed, Mearns and Cooper (2005, p.9) highlight the importance of the
need for ‘something more interactive, bi-di-
rectional and mutual’ in the practice of per-
centred therapy. This in particular is es-
specially relevant for counselling psy-
chology practitioners where emphasis is
placed upon the transactional encounter
and quality of the therapeutic relationship
deemed crucial. In addition, emphasises the
client’s subjective experiencing, values
clients on their own terms, promotes a multi-
plicity of truths, and values a wide ranges of
therapeutic approaches (Strawbridge &
Woolfe, 2003).

Therefore, for the counselling psycholo-
gist, it seems reasonable to speculate that
when it comes to the role of case for-
mulation, rather than regarding it as an inter-
vension to lead, guide or direct the therapeu-
tic process, it may be considered as a function
of the therapeutic process that has the
potential to facilitate the client’s therapeutic
experience, insight and understanding.
Although it is a collaborative endeavour, the
focus, however, is always on the client’s
narrative, remaining within the client’s
frame of reference, with the sole aim of facili-
tating and promoting the client’s under-
standing of his or herself and associated
out that it is not so much what the therapist
does but rather, how it is done. Although the
authors are referring to how to introduce
assessment during clinical practice, the same
idea applies when it comes to introducing
case formulation. That is, asking the client’s
permission as to whether or not they wish to
have a formulation of their difficulties drawn
up and shared with them. In doing so it
respects their autonomy by providing them
with the choice whether to accept or reject it,
thus ensuring that they retain direction of
the therapeutic process.

According to Yalom (2001) therapists are
fellow travellers with their clients as they
journey through therapy and thus a case
formulation may act as a useful map or guide
as both client and therapist embark upon
the unexplored terrain of the client’s mind,
emotions, and significant life events, which
together have led him or her to the current
point in time whereby they find themselves
in therapy. Case formulation helps both
client and therapist alike to make sense of
that. Figure 1 shows a template for embed-
ding client case material within a person-
centred theoretical framework.

In order to illustrate further two fictional
case example are outlined and client mate-
rial embedded within the above formulation.

**Case Example 1**

‘Joe’ was referred for counselling by his GP
due to bouts of low mood and suicidal
ideation. Over the first two sessions it
became clear that Joe was struggling to come
to terms with the fact that he was gay. He was
19-years-old and still living at home. Joe
stated that he was aware from around age
fifteen he was gay but did not want to
admit it to himself. He had spent the past
five years trying to convince himself he was
not gay by having a number of relationships
with females. However, he could no longer
deny to himself that he was not hetero-
sexual as he had started to have a number of one
night stands with males he met through the
internet.

In person-centred terms ‘Joe’ was in a
state of profound incongruence in that he
had not yet ‘come out’ so therefore, he was
presenting himself to the outside world as a
heterosexual male but on the inside
knowing himself to be gay. During the coun-
selling sessions he discussed how his family’s
views on homosexuality were negative and
that they judged such individuals as
‘disgusting’, ‘sick’, ‘downright wrong’ and
‘immoral’. Family expectations of him
related to finding a partner of the opposite
sex, settling down and having a family. At age
nineteen, ‘Joe’s’ parents and siblings were
questioning whether or not he had a girl-
friend and if so, when he was going to bring
her home to meet the family. His mother
often talked about her expectations of
having lots of grandchildren. Consequently,
Joe viewed the future with a degree of
pessimism and hopelessness. In person-
centred terms it can be construed that ‘Joe’s’ actualising tendency had been thwarted as a result of conditions of worth laid down in childhood relating to being heterosexual.

Part of the initial counselling sessions involved ‘Joe’ exploring his own reactions to being gay and the implications this had on his current and future life. Of most difficulty though was how to tell his family. It was at this point in his ‘internal’ journey of coming out that he had reached crisis point whereby his mood had become so low and he felt suicidal as he was finding it more and more of a strain to keep up the façade to his family and friends that he was heterosexual. He felt guilty and shameful of being gay, and fearful of his family’s strong anti-gay views and how they would react when he told them the truth. He was in complete turmoil but at the same time he could no longer continue to be someone he was not. Figure 2 is a tentative formulation of ‘Joe’s’ difficulties embedded within a person-centred theoretical framework.

Case Example 2
Jen, a 29-years-old solicitor was referred to counselling due to low self-worth and low mood. During the assessment she reported that she had recently been promoted and was considered to be one of the brightest, most promising young members of her firm. On the surface she stated that it looks like she ‘has it all’: a good job, busy social life and a number of friends although she is not close to any one person in particular. In fact, she states she finds it hard to get close to people and often feels lonely. She cannot understand how others hold positive opinions of her or even like her at all, as she can clearly see all her flaws.

Three months ago one of the firm’s clients decided to switch to another firm and although the decision was based on factors beyond her control, Jen nonetheless blamed herself. She links this loss with her new role as a result of the promotion. She had been assigned this client and now blames herself for their decision as she believes she did not work hard enough to provide a good standard of service. Since this she found work a
Figure 2: Tentative formulation of ‘Joe’s’ difficulties embedded within a person-centred theoretical framework.

CONDITIONS OF WORTH LAID DOWN IN CHILDHOOD
Being heterosexual is the only natural, appropriate way to be.
  Being gay is sinful and shameful.
Getting married and having children is an expectation.
  A heterosexual family unit is the only moral and acceptable type of family.

INTROJECTED VALUES AND BELIEFS
Being gay is wrong.
Being gay is immoral.
Gay people are disgusting.
There is something wrong with me for being gay.
  I am abnormal.

DENIAL AND DISTORTION OF EXPERIENCE
Mistrust of the organismic valuing system.
  Thwarting of the actualising tendency.

Denial of being gay.
  Engaging in heterosexual relationships by deliberately seeking out female relationships to convince himself he is heterosexual.

STATE OF INCONGRUENCE
Denial of the ‘real self’ as a gay man leading to cognitive, behavioural, emotional and interpersonal difficulties.

PSYCHOLOGICAL DIFFICULTIES
  Depression
  Hopelessness
  Suicidal Ideation
  Tension
  Secrecy
  Shame

Critical incidents:
Developmental stages.
Adolescence (increasing awareness of sexual attraction to males); Young adulthood (gradual acceptance of being gay). Recent behaviour engaging in one night stands with males reinforcing homosexuality.
burden, did not enjoy going in and found when she was there she could not concentrate. In fact, if she was really honest with herself she was deeply unhappy and got no satisfaction out of the work she did.

Further information revealed that she is an only child and endured quite a lonely and isolating childhood. Both her parents are lawyers, who worked long hours and had the expectation that she would follow in their footsteps. Jen would have liked to become a nurse but this was discouraged. Working in a profession that involved displaying emotion and caring for others was unthinkable to her parents. However, given she loved her parents very much and respected them she trusted their judgement as to what was best for her. They prized academic achievement and hard work. They did not encourage her to form friendships. In fact they deemed most people untrustworthy. She described the relationship with her parents as lacking in emotional connection in that she finds them distant and emotionally detached. She does not recall ever feeling loved and displays of affections were forbidden. Despite being a high achiever, Jen states that her parents always pushed her to do better. She could not recall any time in her past when her parents were proud of her, complimented her or supported her. Even her recent promotion had failed to elicit a positive response from them. Furthermore, when she told them of the recent loss of the firm’s client her parents stated that it was her fault and evidence that she clearly ‘wasn’t up to the job’ or ‘worthy of the promotion’.

In person-centred terms it could be construed that Sue’s conditions of worth laid down in childhood related to doing well academically, professionally and always aim to be the best she can be. It was also important that she strived to please her parents and live up to their expectations of her. Relationships were of less value and any expression of emotion deemed a weakness, therefore making it difficult for her to get close to anyone. For many years she had tried to be someone her parents wanted her to be rather than doing a job she deemed worthwhile and an expression of her true self. That is, a caring individual keen to take care of others. Thus, her actualising tendency had been thwarted and she was thrown into a state of incongruence when despite her promotion, which was a marker of her success, the firm lost a client. Blaming herself for this loss despite evidence to the contrary resulted in her feeling depressed, activated feelings of low self-worth and withdrawal from others. Compounding this state of incongruence was the increasing realisation she did not want to be a solicitor and in fact, never did. The self she presented to the world was a facade (Figure 3).

Both these case examples and the formulation of their difficulties embedded within a person-centred framework enables the client to see the connections or ‘join up the dots’ in his or her life from early childhood to present day outlining how a particular difficulty has developed, persisted and the various cognitive, emotional, behavioural effects and interpersonal difficulties generated as a consequence. It enables the counselling psychologist to gain insight into the client’s experiential world and a greater understanding of the unique and individual nature of the client’s issues. It may facilitate empathy by enabling the therapist to illuminate understanding of the meaning of events and their impact upon the individual. Furthermore, it ensures adherence to the theoretical model as the fundamental assumption of person-centred theory and practice is the dissolving of conditions of worth during therapy as a means to improve psychological well-being. As Joseph and Linley (2006, p.43) state ‘... although the actualising tendency is the sole motivational force, it becomes thwarted and usurped by conditions of worth that are introjected from external sources.’ This model is a means by which the therapist can understand how all these elements are inter-related and how they have contributed to the client’s difficulties.
Figure 2: Tentative formulation of ‘Jen’s’ difficulties embedded within a person-centred theoretical framework.

CONDITIONS OF WORTH LAID DOWN IN CHILDHOOD
Parents always know what is best for their children.
Never show emotion, it is a sign of weakness.
Doing one's best is not good enough there is always room to try harder, do better and achieve more.
Happiness can only be achieved from academic and professional success.
It is better not to make friends and get close to people.

INTROJECTED VALUES AND BELIEFS
Failure is bad and unacceptable.
Others cannot be trusted.
When things go wrong it is all my fault.
I must never get close to people.
I must never show my feelings.
My parents know me better than I know myself.

DENIAL AND DISTORTION OF EXPERIENCE
Blaming herself for firm's loss of client.
Unworthy of promotion.
Denial of fact that this career path is not one she willingly chose for herself.
Need for close and confiding relationships.

STATE OF INCONGRUENCE
Despite achievement feels sad and blames self for loss of client.
High profile career/professional position but lack of job satisfaction.
Plenty of friends but not close to anyone.
Need for closeness to others.

PSYCHOLOGICAL DIFFICULTIES
Low mood.
Hopelessness.
Low self-worth.
Social withdrawal.
Poor interpersonal functioning.

Critical incident(s):
Recent promotion.
Loss of client.
Increasing recognition of wrong career path.
Conclusion
The aim of this paper was to discuss the role of case formulation within a person-centred framework for counselling psychologists and whether or not what has been often criticised as being a ‘technique’ driven task aligned with the medical model can actually sit comfortably with the ethos, philosophy and practice of the profession and the theoretical underpinnings of the approach. Although research in the area is limited and the negative effects of introducing case formulation during routine clinical practice have been highlighted, the author nonetheless contends that case formulation within a person-centred theoretical framework does have a role to play. Furthermore, that it can sit comfortably within routine clinical practice so long as it conducted in a way that respects client choice, autonomy and expertise. Remaining within the client’s frame of reference ensures that he or she is facilitated in telling their story in such a way that puts them in the expert position and regards them as the only ‘author’ of his or her life. The role of the counselling psychologist is to hear this story, reflect back the details and piece together the delicate fragments of their life to help him or her make sense of their story. Only the information provided by the client is used. The counselling psychologist, to remain true to a person-centred framework, does not offer up interpretation nor embellish the details provided. This process can be assisted and enhanced by employing the diagrammatic model of person-centred formulation outlined. In doing so, it may enhance client insight, awareness, understanding, strengthen the therapeutic alliance as research shows it can increase empathy. Remaining within the client’s frame of reference ensures a non-judgemental stance, encourage client personal growth and potential all of which ensure a person-centred approach is upheld.

Correspondence
Jane Simms
Chartered Counselling Psychologist,
University of Ulster,
School of Communication,
Newtownabbey,
County Antrim,
BT37 OQB,
Northern Ireland.
Tel: 02890 366957
Email: j.simms@ulster.ac.uk

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Jane Simms
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Theoretical Article

Integration in counselling psychology: To what purpose?

Laura Cutts

Objectives and Conclusions: This paper outlines a critical evaluation of the way in which integration in counselling psychology is presented, and within this two core arguments are laid out. Firstly, the evidence suggesting a move away from the traditional single theoretical approaches is examined, concluding that integration can be a useful means to an end for counselling psychologists. Secondly, it is argued that authors need to be clear about the methods of integration employed, in order to be explicit about the goal of their integration. This is demonstrated by outlining the way in which the end goal can either be integration culminating in new unified models of therapy, or may purely be improvement in outcomes with no reference to a new theoretical base. Furthermore, the methods of integration themselves imply an end goal of integration. That is to say, theoretical integration and assimilative integration suggest that the end goal of integration is the creation of a unified theory; whereas eclecticism, the common factors approach and a pluralistic approach all steer away from the end goal of integration being a unified model. Egan’s Skilled Helper Model (2010) is then critically assessed as an example of the clarity which is needed in the area of integration, concluding that there are implicit theoretical assumptions within the model which are not made clear by the author. From this, it is concluded that being explicit about the goal of one’s integration is important in order for the critical nature of counselling psychology to flourish.

Keywords: integration; counselling psychology; skilled helper; pluralism; common factors.

Integration has been described as ‘...part of the prevailing zeitgeist’ (Norcross & Goldfried, 2005, p.392) and can be seen as the move towards bringing aspects of alternative theoretical approaches and traditions together (Nuttall, 2002). The movement, which can be traced back to the 1960s (Lazarus, 2005), continues to grow and expand. In counselling psychology, a profession where practitioners are encouraged to explore a range of theoretical approaches (Strawbridge & Woolfe, 2010) it has a particular influence (Lampropoulos & Dixon, 2007). Despite its popularity, there appears to be no consensus either on where the integrative movement stands today, or what it is aiming for. This is apparent from Norcross and Goldfried’s (2005) paper in which the 22 contributors from their Handbook of Psychotherapy Integration respond to a number of important questions regarding integration. Therefore, it is a pertinent issue to discuss the position of integration within counselling psychology.

Within this paper it will be concluded that integration can be a useful tool as a means to improving outcomes in therapy and practice in counselling psychology. The end goal of improvement can either be achieved through eclectic or pluralistic approaches, or integrative methods that result in a new single theoretical model. However, in line with the scientist-practitioner model in counselling psychology (Strawbridge & Woolfe, 2010) models and theories need to be open to critical scrutiny and empirical validation (Cooper & McLeod, 2007). Therefore, there is a danger where the literature is not clear on the method of integration and as a result is not clear about the end goal of integration. This is particularly important where a new theoretical model appears to be proposed implicitly under the guise of an eclectic framework,
as in Egan (2010). Let me also note that this is not meant to underplay the reflexive-practitioner model in counselling psychology which I would stress is as important as the scientist-practitioner, if not more so in terms of the profession’s identity. However, it is important to emphasise both the reflexive and the scientific nature of the profession.

**Why is critical scrutiny important in counselling psychology?**

Prior to setting out my argument it seems appropriate to briefly outline why there is a need for critical scrutiny of models within counselling psychology. There is some debate within the literature about the adoption of the scientist-practitioner model in the profession of counselling psychology, which is apparent from the comment that counselling psychology has a ‘disdain of the medical model and problems with the implementation of the scientist-practitioner model…’ (Chwalisz, 2003, p.499). Although, for example, Wampold (2003) objects to the comments made by Chwalisz (2003), it seems clear that the model is not wholly accepted within the field of counselling psychology (e.g. Blair, 2010). Nevertheless, those who object on some level, or those who see many problems with the application of the scientist-practitioner model do appear to recognise the need for some level of research in order for psychologists to be ‘well informed’ (Blair, 2010, p.28). In sum, although there is some debate around the form of that research, the need for critical enquiry in counselling psychology seems to be supported within the literature. I will return now to the main argument.

**Integration: The goal itself?**

Within the Norcross and Goldfried (2005) paper, Scott D. Miller, Barry L. Duncan and Mark A. Hubble were reported to state that ‘the integration movement began as a good will effort to stem the tide of conceptual confusion’ but that it has become the end itself rather than being the means to an end (Norcross & Goldfried, 2005, p.463). They suggest that integration has become the aim itself as opposed to improving outcomes in therapy. Therefore, in considering whether integration in counselling psychology is a means to an end it is firstly necessary to briefly discuss the alternative position; that is to say, holding that integration is the end goal itself.

Feldman and Feldman (Norcross & Goldfried, 2005) suggest that the way forward for the next 25 years in psychotherapy is for integration to become the norm. The problem with this position is that in order for integration to continue, one presupposes that there will be other members of the psychotherapy community continuing to develop single theories and interventions. It would not be possible for all practitioners to be integrating all of the time, as there wouldn’t be anything new for them to integrate. That is to say, integration is a process dependent on the existence of numerous techniques or theories. By analogy fire is a process reliant on a constant input of carbon and oxygen: if you fail to collect wood to fuel the fire it will burn out. Instead the fire is a process, not an object in itself. Both fire and integration could conceivably be desired as ends in themselves, but neither can exist in isolation from their prerequisites. For this reason the suggestion that integration is not the means to an end, but instead the end itself, will not be considered further within this paper. The field of counselling psychology cannot wholly be integrative, only singular practitioners can be. Instead I will focus on whether integration can be a means to improving outcome, how the end goal of integration may be made clear, and finally a demonstration of the danger of a lack of clarity around the end goal of integration.

**Integration as a means to an end – improving client outcome**

In order for integration to be viewed as a useful means, the empirical support for the suggestion that integrative approaches are superior to unitary models needs to be examined (Schottenbauer, Glass & Arnkoff,
Within the Norcross and Goldfried (2005) paper, Castonguay, Holtforth and Maramba go as far as to state that the ‘implicit and sometimes explicit claim’ needs to be examined (Norcross & Goldfried, 2005, p.412, emphasis added); similarly, Anchin (2008, p.2) notes that the integrative movement needs to attend to ‘cultivation of its scientific foundations’. For the purposes of this paper the core argument in favour of integration will be examined, in order to demonstrate the potential efficacy of using integrative techniques.

The main evidence cited in support of integrative endeavours is that there is little or no discernable difference in outcome between the various schools of therapy. This has been described as ‘one of the best established findings in the counselling and psychotherapy research field’ (Cooper, 2008, p.50). The finding serves not as a falsification of single theoretical approaches, but rather as a demonstration that they may not be able to fully account for outcomes in therapy. The effect is known as the ‘equivalent outcome paradox’ (Lampropoulos, 2000, p.416) or the ‘Dodo Bird Verdict’ (Luborsky et al., 2002, p.2).

Asay and Lambert (1999) note that comparative research looking at the effectiveness of one model compared to another has typically demonstrated very few differences between therapeutic approaches. More recently, Luborsky et al. (2002) looked at 17 meta-analyses of comparative research looking at the effectiveness of one method of treatment versus another. Within this, accounting for researcher allegiance, the average difference between the therapeutic models was an effect size of 0.14 (Luborsky et al., 2002). They concluded from their research that Rosenzweig’s Dodo Bird Verdict, that ‘everybody has won, so all shall have prizes’ was supported and there were no significant differences between types of treatment (Luborsky et al., 2002, p.2).

Chwalisz (2003) suggests that meta-analyses have several advantages over other methodological approaches because they combine multiple pieces of evidence. However, a drawback is that mediating and moderating variables can sometimes be hidden by the procedures employed. Consistent with this, in a reaction to the Luborsky et al. (2002) paper, Beutler (2002) attempted to demonstrate that the ‘Dodo Bird is Extinct’, through his criticism of their methodological choices. Specifically, Beutler suggests that:

‘By collapsing all outpatients, regardless of personality and psychopathology, into a single group, those who seek to reveal the Dodo bird assume at the outset that these various qualities do not differentially determine patients’ responses to treatment and could not possibly cancel out meaningful effects by undisclosed heterogeneity’ (Beutler, 2002, p.31).

Luborsky et al. (2002) collapse patients into a number of arbitrary groups, including a group titled ‘mixed neurotics’ with no further explanation of whom this group includes. Beutler (2002) also emphasises that the proponents of the Dodo Bird Verdict are failing to acknowledge the research suggesting that patient-treatment matching has an impact.

It is worth noting that Luborsky et al. (2002) do set out clearly their rationale for looking at meta-analyses to address their research question, using the argument that sample sizes are taken into account and magnitudes of effect sizes are considered, which is a benefit of the procedure over simple comparative research. This is a sensible reason for using this type of method, as although some effects may be hidden it does give a wider picture than comparative studies allow. Nevertheless, further to the criticisms surrounding the use of meta-analyses, Budd and Hughes (2009) point out that assessments of the equivalent outcome paradox or the dodo bird verdict often aggregate a number of randomised controlled trials (RCTs), which are limited in their ability to isolate specific treatment effects and could therefore fail to demonstrate significant effects of therapeutic approach.
In order to resolve the debate surrounding the equivalence outcome paradox, it has been suggested that both specific techniques and non-model related common factors can be utilised in therapy (Chwalisz, 2001). Indeed, the idea that specific techniques and common factors are not mutually exclusive has been suggested by Asay and Lambert (1999). Asay and Lambert (1999) discuss the research findings on factors contributing to outcome in therapy, one of which was ‘specific effects’ where they demonstrated that some therapies have been found to be particularly efficacious with particular types of problems. More recently, Cooper (2008) argues that this compromise position accounts for a wealth of research evidence, which has both indicated a role for specific models as effective with specific issues, and that most therapies appear to be as effective as each other, as well as research looking at what the client found beneficial, as this tends to include a range of specific and non-specific factors.

The evidence presented appears to demonstrate that the current unitary models are not the single determining factor in successful therapy. It is important to note that what this does not demonstrate is that integration is necessarily better than unitary models, nor does it disregard the specific effects documented, for example, by Cooper (2008). It does, however, suggest that in order to improve outcomes, researchers and practitioners may wish to look towards integration across models. This can be done in various ways, as will be discussed, and in purely stating that integration may be a means to improving outcomes in therapy, one is not stating whether this is through achieving a new unitary approach or through integration itself. The various integrative approaches and these two viewpoints will be addressed next.

**Integrative methods as an indication of an underlying goal**

Most authors would agree that they are employing integration as a method of improving outcomes (Lampropoulos & Dixon, 2007; Lazarus, 2005; Norcross & Beutler, 2000; Nuttall, 2002) but, as previously stated, there is no consensus on whether the integration movement is working towards a new model of therapy, or moving away from single model approaches themselves (Norcross & Goldfried, 2005). Nevertheless, specific authors’ intentions or goals of integration can be seen through their choice of specific integrative methods. Within this section I will set out the way in which authors do this, by briefly considering the various integrative approaches within the literature.

Eclecticism can be defined as the use of techniques from a variety of sources without regard for theory (Hollanders, 1999). Therefore, in choosing to employ an eclectic approach one is pursuing a line of integration which aims to improve outcomes without the creation of a new theory or model. A problem with the eclectic method of integration is that there needs to be some criteria in place for guiding the decision making process on the part of the therapist or psychologist (McLeod, 2009). Decision making is, therefore, particularly pertinent in eclecticism; however, there is still a paucity of research looking at the way in which therapists and psychologists make decisions in practice (Schottenbauer et al., 2007). A development from eclecticism known as technical eclecticism specifies that the decision making process should be directed by the current research evidence. This allows for a more systematic approach, although there are still some concerns about what evidence is being used to guide decisions. Furthermore, opponents of eclecticism might suggest that techniques may clash, for example in the case of person centred methods and those from a cognitive-behavioural paradigm; Hollanders (1999, p.487) discusses this issue as the ‘incommensurability of paradigms’. Nevertheless Lazarus (1989, 2005), advocating the use of technical eclecticism in therapy, suggests that within an eclectic approach one does not need to subscribe to the theories from which the techniques originate from. He specifically
sets out his goals of integration by stating that what is important in therapeutic practice is the employment of empirically validated techniques and approaches, as opposed to a unified theory.

Advocates of the Common Factors Approach to integration suggest that ‘...much of what is effective in psychotherapy is attributable to pan theoretical or common factors, those shared by many schools of therapy’ (Asay & Lambert, 1999, p.23). Along with the equivalence outcome discussed in the previous section, proponents of the common factors approach cite the evidence that paraprofessional counsellors trained in a short course on counselling skills focusing on common factors can be just as effective as trained professionals, and that when they are asked, clients cite non-specific factors as being important in relation to therapy outcomes (McLeod, 2009). Although it has been suggested that the common factors are classifiable into characteristics of the client, the therapeutic relationship, treatment structure, therapist qualities and change processes (Bickman, 2005) there is no consensus in the literature on what these common factors are (Lampropoulos, 2000). With regards to the therapeutic relationship there has been some further specificity; the American Psychological Association’s Division 29 Task Force on Empirically Supported Relationships assessed the research literature and concluded that certain qualities of the relationship were either ‘demonstrably effective’, ‘promising and probably effective’ or had ‘insufficient research to judge’ (Norcross, 2002, p.8). As Norcross acknowledges, this is limited purely to looking at therapist relationship behaviours, and therefore does not wholly conclude the discussion on what the common factors are in therapy. A further concern surrounding the common factors approach has been that therapists could pick at random the technique which suited them at the time (Chwalisz, 2001). Despite this, one thing is clear from the common factors approach to integration, in that looking at pan theoretical factors it explicitly details a move away from unified theories, similar to the eclectic approaches discussed previously.

The pluralistic philosophy in relation to psychology encapsulates the idea that a question can be followed by numerous conflicting responses which are equally plausible, therefore numerous explanations of the human mind can be true (Cooper & McLeod, 2007). In their pluralistic approach set out in their 2007 paper and more recently their 2011 book, Mick Cooper and John McLeod are clear about the way that they see integration as a means to individualising therapy for the client, because a pluralistic approach allows for integration across models and traditions (Cooper & McLeod, 2007, 2011). Within pluralistic counselling, the therapist does not select methods for the client; instead the client is an active change agent within the therapeutic process. The therapist and client collaborate on setting goals, tasks and methods for the course of counselling (Cooper & McLeod, 2011). Perhaps in contrast to the eclectic approaches discussed above, the pluralistic framework explicitly sets out that decisions on technique (method) should emerge through a dialogue between client and therapist, rather than this being dictated purely by research evidence (Cooper & McLeod, 2011). In relation to examining what the end goal of integration is pluralism provides us with a direct example of one which explicitly stands opposed to any movement toward a unified approach. Cooper and McLeod (2011) note that their pluralistic approach in psychology represents an ethical rather than epistemological position; specifically, that any attempt to reduce human experience into a single theory can be classed as potentially dangerous, as they suggest it can lead to inhumanities. When referring to the various models of psychological distress within the literature, Cooper and McLeod (2007, p.137) suggest that there is ‘no need to try and reduce these into one, unified model’.

Theoretical integration involves using a combination of approaches and techniques
to develop a coherent unified model encompassing a formulation of specific problems, a theory of the change process, and a decision making model regarding the sequence of interventions (Wolfe, 2000). Models under this category tend to posit a single theoretical concept to hold at the core of the model into which aspects of various approaches are integrated (McLeod, 2009). A commonly cited example of theoretical integration is Anthony Ryle’s Cognitive Analytic Therapy (CAT), which encompasses ideas from cognitive therapy, psychoanalysis and developmental psychology (McLeod, 2009). The presence of a ‘unified model’ as the end product from the process of integration explicitly sets out the goal of integration for models which advocate the use of theoretical integration.

Assimilative Integration has been proposed by Lampropoulos (2001, p.9) as a ‘bridge between theoretical integration and technical eclecticism’. Proponents of assimilative integration posit that the chances are high that one will not, or cannot, achieve a new theory based on theoretical integration, as it would be impossible to integrate all aspects of two theories together in a coherent manner, and that one will not, or cannot, achieve complete technical eclecticism as it would not be possible to treat all situations and clients in a scientific manner, using only evidence-based treatments. Therefore, assimilative integration can reconcile those two integrative approaches by taking one’s core theoretical approach and merely incorporating techniques which may benefit the original theory. An example of assimilative integration would be incorporating aspects of cognitive and behavioural interventions in order to improve psychodynamic models of therapy (Lampropoulos, 2001). One would assimilate interventions from outside one’s core theoretical model whilst maintaining a coherent theoretical basis to the therapeutic approach. The technique of assimilative integration proposed by Lampropoulos (2001), therefore, expresses a goal of maintaining a single theoretical approach, which has merely been updated by the integrative process.

In sum, the methods of integration employed in the literature indicate each of their underlying goals. In all of the literature discussed so far however, the authors have been clear on their position with regards to integration, whether it be eclecticism or integration. A problem arises when it is unclear or there is some debate surrounding this, as the goal of integration is obscured; the existence of a theory or model as a result of integration needs to be examined critically within the literature. As Blair (2010, p.24) clearly sets out, ‘research plays a key role in the scientist-practitioner model’. In the following section I will use the Skilled Helper Model (Egan, 2010) as an example of a model where there is a lack of clarity surrounding the integrative approach taken, and following this I will consider the impacts of this on research.

Where the end goal is obscured
Egan’s Skilled Helper Model (2010) model has been described as drawing from cognitive behavioural, and humanistic philosophies (Wosket, 2006), and Egan (2010) defines it as an open systems approach, grounded in an ideology of problem management and opportunity development. In being derivative and incorporating aspects of more than one approach, it seems apparent that the Skilled Helper Model is certainly ‘integrative’ in the broadest sense of the word. Although Egan (2010) does discuss eclecticism and integration within the most current edition of his text, he does not go as far as to explicitly state the approach which the Skilled Helper takes towards integrating these different models. Furthermore, it seems that as a result of this there is a disagreement within the literature about whether the model can be seen as eclectic or integrative; for example, take the contrasting ideas of Jenkins (2000), McLeod (2009) and Wosket (2006) with regards to the model’s integrative stance.

Wosket (2006) identifies that the distinction between integration and eclecticism is
not always straightforward and moreover that the distinction is relatively unimportant. Consistent with the assertion that the distinction is complex, Hollanders (1999) indicates that the boundary between the two approaches can be blurred, and that it is best to consider them on a spectrum where some approaches nearer the centre of the spectrum will have ‘varying degrees of combinations of theories and techniques’ (Hollanders, 1999, p.484). Wosket (2006) goes on to suggest that the Skilled Helper sits most comfortably in the middle of this spectrum. It is important to note, however, that Wosket’s comment that it matters little whether the Skilled Helper is classed as integrative or eclectic is, in my opinion, flawed (Wosket, 2006). This is evidenced by the previous discussion, in that the approach taken to integration indicates an end goal of the process. Thus, clarity on integrative methods allows for the appropriate critical analysis of any model or framework proposed, consistent with the scientist-practitioner approach taken by counselling psychologists (Strawbridge & Woolfe, 2010). Therefore, it is important for the integrative approach taken within the Skilled Helper to be clarified. The following discussion will address this issue.

For the model to be eclectic it would have to be consistent with the definitions discussed previously, in that it would have little regard for theory (Hollanders, 1999) and, if systematically or technically eclectic, techniques and treatments would be selected on the basis of current research (Lazarus, 2005). In line with this, Egan places a significant emphasis on the systematic nature of integration, stating that eclectic approaches need frameworks to give them coherence (Egan, 2010). Furthermore, Egan has established an approach which has regularly been updated by research findings, and he suggests that in order to choose appropriate techniques to use within the ‘framework’ the helper should refer to the literature surrounding those techniques (Egan, 2010). This is consistent with a technical eclectic position similar to that of Lazarus (2005) in that there is a direct appeal to the evidence base for methods. Additionally, in describing his model as a ‘framework’ (Egan, 2010, p.87), he appears to be indicating, or at least implying, an eclectic approach to integration. Although having a number of similarities and overlaps with the eclecticism movement, I would hold that Egan appears to outwardly suggest a systematic eclectic approach whilst implicitly advocating an underlying theory on which the model is based.

In order for the model to be defined as theoretical integration or assimilative integration there would need to be an attempt to create a new coherent theory through the integration of diverse concepts (Hollanders, 1999), either from combining two models (theoretical integration) or where an initial core model is adapted in the light of other theories (assimilative integration). Therefore, in order to assess whether or not the Skilled Helper is theoretical or assimilative integration, I will consider whether the model satisfies the sufficient conditions to be classed as a theory. McLeod (2009) discusses the concepts which comprise a theory as being on three levels: the philosophical level, specific theoretical propositions and concepts that function as ‘labels’. For the purposes of this paper, these levels will be treated as the sufficient conditions of the concept ‘theory’. Following outlining these levels, in a discussion of various aspects of the concept ‘theory’ McLeod (2009) also sets out that a theory is a structured set of ideas. I would argue, however, that this is not a necessary condition for the definition to hold; even as McLeod himself points out, although it is possible, it is rare in counselling for authors to write up their theories in this formal sense. It is possible for one to hold theoretical commitments without making them explicit. Similarly there are other hallmarks of a theory which are not considered here, as they are not necessary in order for the Skilled Helper to be classed as a theory.
It is now necessary to address whether the Skilled Helper Model has sufficient concepts to compromise a theory, as described by McLeod (2009). Firstly, in addressing the philosophical level of Egan’s model I will consider whether the Skilled Helper holds any ‘philosophical or ‘metapsychological assumptions’ (McLeod, 2009, p.49). These can be seen throughout the first chapter of his ninth edition, ‘Introduction to Helping’. For example, Egan sets out that a client comes to therapy either because of problem situations they are not managing or because they are ‘not living as fully as they might’ (Egan, 2010, p.5). The model takes a problem-management and action-oriented approach which rests on this postulate. Furthermore, as Wosket (2006) states, Egan’s framework rests on the basic assumption that people need to acquire the necessary skills and knowledge at each developmental stage of their life, and problems arise where they do not reach their potential in relation to these developmental tasks. That is to say individuals experience distress where they have failed to acquire the necessary skills and knowledge. These assumptions are similar to the way in which the psychoanalytic approach rests on the philosophical assumption of the unconscious (McLeod, 2009).

Additionally I would argue that Egan (2010) also uses a specific theoretical language or system of labels. Within the Skilled Helper the concept of ‘blind spots’ is discussed in detail (Egan, 2010, p.223), to refer to an idea or feeling that the client is failing to see, or be aware of. Egan describes them as being either unintentional or inflicted by the self. Consistent with McLeod’s view of the concepts which operate referentially, Egan’s blind spots are part of the terminology used by adherents of the Skilled Helper Model (e.g. Wosket, 2006).

In sum, it is clear that Egan (2010) also uses a specific theoretical language or system of labels. Within the Skilled Helper the concept of ‘blind spots’ is discussed in detail (Egan, 2010, p.223), to refer to an idea or feeling that the client is failing to see, or be aware of. Egan describes them as being either unintentional or inflicted by the self. Consistent with McLeod’s view of the concepts which operate referentially, Egan’s blind spots are part of the terminology used by adherents of the Skilled Helper Model (e.g. Wosket, 2006).

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In sum, it is clear that the Skilled Helper is implicitly setting out a theory of change consistent with the view of theory taken from McLeod (2009). This is also consistent with the suggestion made by Cooper and McLeod (2007). It is worth noting that the hypotheses and assumptions made may indeed be found to hold true. Nevertheless, because these theoretical assertions are implicit, despite the fact that the claims may be true research has not addressed the issues.
Implications for research
A regular criticism of the model is that there is no research base supporting its efficacy in therapy (Wosket, 2006). I would argue that in part this is due to the confusion detailed above about the Skilled Helper’s method of integration, combined with a misconception about the accessibility of eclectic approaches to research. I will firstly address this misconception.

Wosket (2006, p. 171) suggests that despite there being no research directly assessing the model, Egan acts as a ‘translator’ combining techniques which have a strong evidence base. Wosket (2006) also makes the claim that integrative approaches like the Skilled Helper are not able to be researched empirically similar to a single approach. Wosket appears to be suggesting that, as each client would receive different and individualised therapy, it would not be possible to conduct outcome research for the model. However, as Arnkoff, Glass and Schottenbauer point out you can assess these types of approaches where there is a system in place through which to decide upon techniques (in Norcross & Goldfried, 2005). If the system was being followed then one could assess outcomes. Therefore, even if the framework were to be truly eclectic, research should follow in order to assess its validity.

Furthermore, as demonstrated previously, there are implicit theoretical assumptions within the model. As this theory is not explicit in the works of Egan they have not been subjected to empirical testing. The model has been allowed to forego critical scrutiny under the guise of being an eclectic framework. Specifically, it seems that a potential explanation for the lack of research looking at the Skilled Helper Model may be due to the portrayal of the model as an eclectic system, combined with this misconception. Egan’s Skilled Helper Model (2010), therefore, provides us with an example of the way in which a lack of clarity around the goals of integrative approaches and methods can result in a model not being assessed in a rigorous manner.

Conclusion
Although the integration movement proves popular in counselling psychology, there is a lack of consensus on a number of key issues in the area (Norcross & Goldfried, 2005). This paper aimed to demonstrate the need for clarity within the movement. The original focus of this paper ‘Integration in counselling psychology: To what purpose?’ has been addressed by firstly setting out that although the traditional unified approaches do contribute to outcomes, they do not significantly impact a large amount of outcome in therapy, and the evidence surrounding the Dodo Bird Verdict suggests that counselling psychologists may wish to pursue lines of integration across approaches in order to improve outcomes in therapy. This demonstrated that yes, integration may be a means to improving outcomes, but did not provide further clarity. Specifically, it was noted that within the integrative field, authors appear to be setting out their ‘end goals’ of integration implicitly (and occasionally explicitly) through their chosen methods of integration. These are suggested to fall into approaches such as theoretical integration and assimilative integration which produce a single theoretical approach as the end product, whilst those in the eclectic and pluralistic camps aim to improve outcome without reference to, and therefore without the creation of, any coherent theory.

It was further argued that a problem arises for counselling psychology where an author is not clear with regards to the method of integration taken, and, therefore, their ‘end goal’ of integration. The Skilled Helper Model of Egan (2010) was considered as an example of this problem, as there is some debate surrounding the approach taken to integration. On examination, it was concluded that although having similarities and overlaps with the eclectic approach, Egan posits several implicit theoretical propositions and assumptions. This has problems for the scientist-practitioner model within counselling psychology, as appropriate critical scrutiny of the model has not
followed in the form of research, which is in part attributable to this lack of clarity surrounding integrative methods. To conclude, integration may be a means to an end, but because as yet there is no consensus on the goals of such practice, it is imperative that authors set out integrative approaches with clarity.

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References


About the Author
Laura Cutts is a trainee on the Doctorate in Counselling Psychology at the University of Manchester.

Correspondence
Email: laura.cutts-2@postgrad.manchester.ac.uk


Theoretical Article

Cognitive Relational Therapy

Yvonne Walsh & Alan Frankland

Content and Focus: This paper describes the development of Cognitive Relational Therapy (CRT), a method of working therapeutically at the intersection between Beck’s Cognitive Therapy and Rogers’ Person-Centred Approach (PCA).

Conclusions: Seven arguments are suggested as to how Cognitive Therapy and the Person-Centred Approach intersect. It is posited that: (1) both are meta-theories; (2) there are similarities between the concepts of schema and conditions of worth; (3) the aim or process of therapy in both orientations is to shift the schemata/conditions of worth; (4) both work through the relationship; (5) it is argued that both include a phenomenological focus on client experience; (6) both models are developmental; and (7) both are social constructivist.

Keywords: cognitive therapy; cognitive relational therapy; person-centred therapy.

The evolution of Cognitive Relational Therapy

What we have begun to call Cognitive Relational Therapy (CRT) is not so much an attempt to create an integrative theory of therapy, but a model of working which explicitly recognises and draws on the strengths of two (sometimes apparently diverse) theories in an attempt to produce more effective outcomes for clients.

CRT has come about as the result of a long-term collaboration between the two authors of this paper, which began six years ago during a period of job-sharing that resulted in the need for each of us to make sense of the other’s therapeutic approach; one coming from 20+ years as primarily a person-centred practitioner and the other rooted in Beck’s vision of cognitive therapy for 18 years. The evolution of this working model hangs on a slightly tongue-in-cheek early declaration that ‘I must be a person-centred therapist without knowing it!’ from the cognitive practitioner in response to the assertion that, from a person-centred perspective, when any therapy could be shown to work it must be that Rogers’ six necessary conditions were present (Rogers, 1957, 1959). The resultant discussion led to three workshops run at the British Psychological Society’s Counselling Psychology Annual Conferences, over a period of about five years, in which some of the similarities and differences between the person-centred approach (PCA: Rogers, 1951 onwards) and the cognitive approach (Beck, 1961 onwards), were explored with workshop participants. This paper continues this exploration. Although it has sometimes been argued that it is not necessary to provide background theoretical information to enable counselling psychologists to explore these two approaches, this has not always been our experience in the workshops or elsewhere. This may be because, within the training experience of many counselling psychologists, the person-centred approach is often reduced to the (three) ‘core conditions’ and a handful of skills as part of an eclectic background to initial work with clients. Likewise, the cognitive approach seems to get wholly swallowed up into cognitive behavioural therapy (CBT) with more emphasis on symptom specific work practices for moderating client behaviours than on the underlying model that Beck himself created. So we will begin by setting the scene...
with a brief characterisation of each of the approaches as each of us understand and work with them.

**Theoretical underpinnings**

**Rogers’ Person-Centred Approach**

Although humanistic psychology has sometimes been perceived as having some difficulties in providing a strong formal evidential base for its theoretical formulations, the person-centred approach (Rogers, 1951 onwards) does have a research basis in Rogers’ own work and in more recent studies (e.g. Cooper, Watson & Hölldampf, 2010). This is both from those clearly identified with the PCA (see, for example, Bozarth, 1998), and others taking a more neutral stand (see, for example, Hubble, Duncan & Miller, 1999).

Carl Rogers’ (1951) theory of therapy developed in his clinical (and later academic and more experimental) enquiry into effective practice, when as a young practitioner he found the authoritative psychodynamic models from his training were not helping the young people and families he was working with. He began to evolve a new approach to practice which emphasised non-directivity and he gradually teased out six conditions for effective personality change. From that he then backfilled these thoughts to create a whole theory of the person and of personal change (Gillon, 2007).

The person-centred approach is often misperceived as exclusively about a non-directive approach to clients’ feelings. This is mistaken, Rogers (a psychologist through and through) did not write so much about feelings as about experiences and how we respond and make sense of them. In many senses the approach presents a model which is a meta-theory of helping and human relations. His model clearly includes the notion that it is not what happens to us but how we perceive it and respond to it; it is what we make of what happens that counts. The theory underlying the therapy is an attempt to make scientific statements with an evidential base out of data that has to be handled phenomenologically. Therapist contributions within the therapeutic relationship are aimed to enable the client to access their whole experiencing so that it can be accepted allowing the dissolution of conditions of worth.

Although Rogers’ underlying model is developmental he does not set out a stage theory involving complex personality structures. Instead he takes a phenomenological approach emphasising the individual’s subjective experiences as their frame of reference to the world. The theory centres on the idea that the human organism has an innate underlying actualising tendency, which leads the organismic self to strive to develop all of its capacities and potentialities in ways that maintain or enhance the organism, so enabling it to develop towards autonomy and fulfilment. This tendency is understood to be directional, constructive and present in all living things. As the actualising tendency is a fundamental drive within the organism it can be suppressed, but it cannot be destroyed without destroying the organism (Rogers, 1977).

According to the classical tradition of the PCA the concept of the actualising tendency is the only motivational force in Rogers’ theory. It encompasses all motivations, needs or drive reductions, and creative as well as pleasure-seeking tendencies (Rogers, 1959).

Rogers described the ‘Self-Actualising Tendency’ as the psychological form of the actualising tendency, which functions in relation to the ‘self’ of the individual. It can be conceptualised as the tendency to develop (or actualise) all of the capacities and potentials of one’s self and self-concept (Rogers, 1959). The tendency towards actualisation when focussed on the developing self-concept creates a sub-system of secondary needs. Rogers has described these as firstly the need for positive regard from others and subsequently an internalised version of this; the need for positive self-regard. The drive to fulfil these secondary needs increases the likelihood that the individual will behave in a
manner that is consistent with the conditions of worth constructed by those who care for them and later will maintain their self-concept even in the face of contradictory experience.

The individual’s self-concept thus becomes based on their experience of others’ standards and expectations, rather than just on how the untrammelled organismic self would evaluate its experience. In an unconditional environment the organismic valuing process ensures that experiences (including how one reacts to them i.e. how one behaves) are accurately symbolised and valued according to how the individual judges their assistance in moving towards optimal enhancement of the organism and self (Rogers, 1959). However, in a conditional environment the individual’s need for positive self-regard tends to create selective perceptions of experience in terms of the externally derived conditions of worth and the perceptions of the experiences that are in accordance with these conditions being symbolised in awareness. Eventually, those responses, which are not in concordance with the conditions of worth that are now subsumed within the individual, are distorted or denied, and this leads to increasing incongruence between the perceived self and the actual experience of the organism, generating confusion, tension, and maladaptive behaviour.

In an ideal world the individual would only experience unconditional positive regard with no conditions of worth being imposed on them, so that their self evaluations derived from their need for positive regard from others and positive self-regard, would match their own organismic evaluation, resulting in congruence between self and experience. This then would produce an individual who is a fully functioning person, open to experience and able to live existentially, trusting in her own organism and organismic way of valuing. This self-actualised person would express feelings freely, act independently and creatively and live a richer fuller life; in Rogers’ (1951) terms they would be living the good life.

Therapy within this approach is therefore a process in which the individual strives to return to a more organismic expression of the actualising tendency through a resolution of past conditions of worth, brought about in and through a relationship characterised by Rogers’ six conditions for constructive personality change (1957, 1959).

**Beck’s Cognitive Therapy**

Like Rogers, Beck’s early training in therapy had its basis in psychoanalytic thinking, but the approach to psychological disturbance/dysfunction he elaborated is firmly based in a modernist medical model of psychopathology. Beck’s approach developed from his original research in the early sixties into the psychodynamic conceptualisation of depression (1961 onwards) and his clinical observations of the ways in which his patients’ thoughts impacted their progress in therapy.

Beck’s (1967 onwards) cognitive developmental theory maintains that in our interpersonal relationships we develop schemata for psychological operations, which seem to work automatically without much evidence of conscious thought, deliberation or reflection and can be applied to many situations (Beck, 1976; Beck, et al., 1983). Although cognitive theory and therapy clearly focus attention on thoughts, it also utilises the idea of a triad consisting of feelings, thoughts and behaviours that are interactive and reciprocal in that feelings can affect thoughts, thoughts can affect behaviour and behaviour can affect feelings and vice-versa.

Beck’s theory also identifies that psychological distress arises from errors in logic, for example, psychologically distressed people often exhibit arbitrary, inaccurate and frequently self-blaming inferences. When automatic thoughts are self-defeating or falsely negative they can have serious effects on emotional and mental health. If an individual continually tells themself that they are useless or inadequate (or if powerful others do the same) it can become a self-fulfilling prophecy.
Beck (1976) describes how psychological problems result from commonplace processes and are not necessarily the product of mysterious, impenetrable forces. An individual might start with negative thoughts about herself; feeling defective, worthless, inadequate; these are a product of developmental experiences (Brown & Harris, 1978). They then lead to elaborated negative schemata, which shape their perception of present day experiences (Persons, 1989).

This theory serves to illustrate quite well how childhood experiences, which fashion the beliefs one holds, can enmesh with those experiences and beliefs adopted as an adult to engender psychological distress. It proposes that people develop schemata, which enable them to function in a complex social world. These schemata are frameworks that shape one’s knowledge of self and understanding of others and the world. Elaborated schemata generate conditional beliefs, which govern the way in which individuals process their world, their expectations of that world and their behaviour in that world.

In later work Beck describes an expanded cognitive theory. This theory not only encompasses a model of individual schemata, initially characterised as linear schematic processing, but also elaborates this earlier linear model to one in which there are ‘more global constructs’ (Beck, 1996, p.1), i.e. a complex, rather than linear, organisation of schemata. It also includes the notion of a predisposition combining with a stressor (the Stress-Diathesis Model), which acknowledges a wide variety of ‘normal’ reactions from different individuals who have the ‘same’ experiences. This also helps to explain the diverse intensities of reaction within the same individual to a given set of circumstances over time.

This theory is one in which a predisposition to functioning within certain primal modes (specific sub organisations within the personality, which are then elaborated through individual experiences) is innate within the individual, are manifest given the right combination of diathesis and stressor (triggering experience). This combination activates an orienting schema, which brings into play global schemata which are active in all domains of functioning; cognitive, affective physiological and behavioural. By continuing to develop cognitive theory to incorporate modes, Beck moves this meta-theory beyond schema reconstruction to the acknowledgement of the innate predisposition within an individual and the construction of particular categories of schemata. These schemata are constructed within the individual when this innate predisposition is paired with certain categories of life experiences.

Individuals who have life experiences that are mode congruent in later life will go on to elaborate the schemata they developed as children. Beck also identified orienting schema, which in a congruent situation trigger elaborated schema active in specific modes of functioning. Such systems, however, can be modified or even deactivated by what Beck called the conscious control system and it is this that is the focus of therapy.

Bringing these two theories together
There are a number of parallels and intersections within these conceptualisations that make it possible to work with them together (although we are not claiming complete theoretical integration is the way forward at this point). In the following sections we outline these points of commonality in turn before discussing these in practice with a fictional therapeutic case.

Meta-perspectives
Although both approaches are sometimes represented as very specific guidelines for a particular type of therapeutic intervention, it is at least arguable that both have within them an approach to personality and therapeutic change which might account for the ways people operate and the ways change takes place in therapy, even if the change agent is not aware of or consciously using
that model. Each offers a meta-perspective on such change.

Beck’s model concerning relevant subsystems of personality, notably affect, behaviour, cognition, motivation, physiology and mood (Beck, 1996), is not solely focused on psychopathology or dysfunction (or simply on psychotherapeutic change). Beck’s theory (1983, 1996) enables an integrative view of the subsystems at work within an individual and gives a coherent explanation of the interplay between the different subsystems, the individual’s response and the role of schema construction within individual development. Beck himself described his model very simply by saying that people have certain ways of thinking about the world, which generally originate as a result of their early experiences and relationships, and are elaborated over time into more complex structures for living (schemata). When such a schema is activated it controls feelings and behaviour, over-riding other aspects of their personality. His expanded model provides a framework for understanding the complex relationships between thoughts, feelings, behaviour and motivation (Beck, 1996; Bloch, 2004).

Rogers’ conceptualisation of the person is in some ways very different, but his model too can be seen to give an account of how psychological processes like affect and cognition (experiencing) and motivation operate within the person and of how the internal systems that manage behaviour develop and might change, through constructs like actualisation and conditions of worth.

**Developmental orientation**

Although originally developed within a modernist medical conception of psychopathology Beck’s approach can certainly be seen to include a cognitive developmental model, which seeks to describe and explain how our orientation to the world comes about. Like the PGA this is not a detailed age-specific account, but is one in which the individual’s development is understood as related to their response to their subjective experiences of the world (Alford & Beck, 1997) and the ways in which these experiences and responses pattern blue prints for living. Both approaches propose powerful innate processes which shape the individual’s relationship with their environment.

**Schemata**

It is hard to miss the parallels between schemata and conditions of worth, with both potentially being thought of as providing blue prints for living. Furthermore, both principally originate as a consequence of early experiences and relationships, are developed and may further be elaborated by subsequent experiences, they shape our perception of the world, predicate affect and behaviour and are open to change. Although they have developed the constructs from very different directions, both approaches have this central notion that through our experience of the world and our relationships we develop cognitive structures which provide the organisational bases that shape our thoughts, feelings and behaviour.

**Focus of therapeutic effort**

In terms of what happens in the room, the language may be different and the directivity of the therapist noticeably so in some cases, but it is at least arguable that the same process is being engineered in the therapeutic relationship. In cognitive therapy the therapist works with the client to test the veracity of the problematic schemata using a variety of methods such as behavioural experiments, examining the evidential base for cognitions and techniques such as Socratic questioning to challenge the logic of the blue print these clients are using for living. The person-centred therapist would normally understand what they do as a relational process of empathic responding and unconditional acceptance, so that the resulting relationship is one in which the client feels safe enough to loosen the boundaries of the conditions of worth by which they are constrained (Bozarth, 1998).
Relationship
These initial parallels within the central constructs of both approaches have encouraged us to begin to explore further potential links between the two. Regarding the role of the relationship in the therapeutic process, in the person-centred approach relational qualities are seen as the necessary and sufficient factor in the process of change, whereas it would be suggested that in cognitive therapy the relationship is necessary, but not necessarily sufficient for the client to enact the changes they desire. From that perspective it is active challenge to cognitions which enables maladaptive schemata to be identified, tested and reshaped. However, Young, Klosko and Weishaar in Schema Therapy have pointed out that the learning or reshaping of complex schemata may be less a matter of specific cognitive techniques and more a question of the realignment of core beliefs brought about by new relational experiences (Young et al., 2003).

Phenomenology
Many practitioners from a humanistic and person-centred perspective perceive a cognitive approach as authoritative and labelling, but in reality both approaches would recognise that effective work, which will lead to genuine change of conditions of worth/ schemata, will only come about through an expanded understanding of the client’s ‘blueprint for living’. This cannot happen if the therapist is only interested in their ‘objective’ view of the client’s world. It has to grow from the client’s perceptions and understanding of their experience. There is, nevertheless, an interesting debate to be had as to what degrees both of these primary models are phenomenological.

Social constructivism
Both models can be seen as social constructivist in that conditions of worth develop in response to (initially) the primary care giver’s interactions with the individual. Both schema and conditions of worth are open to change either by elaboration or adaptation as the individual is involved in socially constructed life experiences which impact on their ways of being in the world, and their perception of the world.

In practice
To make these points of intersection clearer let us consider the case of Judy. Judy has acknowledged that she needs to see someone to help with her low self-esteem and lack of assertion which is affecting her work performance and has accepted a referral to the psychologist at her Trust’s Occupational Health Service.

Rick, the psychologist, has only a brief referral letter concerning Judy and her problems at work, and knows he has just twelve sessions to try to help her. Using a CRT model he approaches the first session alert to information that will help him to begin to get an understanding of the experiences and schemata which shape Judy’s approach to the world. His primary concern in these early stages is to facilitate the development of a real relationship with Judy through which they can work together.

During the next few sessions, after checking that Judy has understood and agrees to the contractual elements of the work they are undertaking together, (agreed in the first session) Rick listens carefully for more information on how she sees the world, as well as using empathy to help Judy clarify her understanding of her situation. Although Judy had seemed quite forthcoming in the first session and still seems quite comfortable in the relationship, she becomes increasingly quiet; appearing stuck and lost as to how to proceed. Rick, therefore, moves towards a more active position and asks Judy directly about her experience of not talking so much in the sessions. Sometimes using simple empathic responses and sometimes working with Socratic questioning to explore this.

In this way it gradually becomes clear that Judy has underlying fears of the outcome of
‘getting it wrong’ and displeasing Rick. It emerges that in childhood she experienced a volatile and inconsistent mother and a father who was often absent and even when at home frequently drank too much. Rick becomes aware from the way she phrases her description of her early parenting (and aspects of her current work situation) that her self talk (possibly indicating core beliefs) is belittling of herself to minimise the risk of failure and punishment.

This provides a focus for the second half of the work, which Rick seeks to address through the complex balance of challenging the validity of her beliefs, accepting that they made sense in the environment that she was brought up in, whilst empathising with their emotional impact and respecting her struggle with them.

Over time, as Judy begins to feel both heard and validated in this process and safe enough in the relationship with Rick to experiment with change, she begins to alter her view of herself, becoming released from the impact of her early socialisation, finding it easier to be a little less timid and more assertive. Judy likes herself better like this.

As they reach the twelfth session and have a final review of their work together it is clear to them both that some progress has been made with a shift in her blue print for living. Judy attributes her progress both to the techniques and skills that she has learnt and the relationship in which she has worked.

**Summary**

The cognitive relational approach is not an eclectic approach to delivering therapy, it is an integrative approach that is developing into a sound theoretical foundation for practice. It does not prescribe a particular way of working with clients so much as begins to develop a common conceptualisation of a meta-theory of change. In the therapy room a cognitive relational therapy practitioner may sometimes operate in ways that would be very familiar to a cognitive therapist and at other times their contributions would appear more like that of a person-centred therapist and the same would apply in reverse to the person-centred therapist. The unifying factors would be in a fundamental recognition from both that the relationship is not just an adjunct of therapy but it is the crucible in which the change process takes place. With some clients the relational content will include fairly direct contributions concerning the ways in which the client thinks about themselves and the world, whilst other times such contributions will be implicit in the relationship itself.

In practice it is probable that many counselling psychologists and other colleagues will recognise aspects of what they might do in both the case above and this description of CRT, even if they have not theorised it in this way. We therefore hope that such colleagues will engage with us in debating and possibly elaborating (or even researching) this preliminary model.

**About the Authors**

Dr Yvonne Walsh
North East London Foundation Trust.

Alan Frankland
APSI and Apsilon SE9

**Correspondence**

Email: apsi@btinternet.com
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Theoretical Article

Is it time we turn towards ‘third wave’ therapies to treat depression in primary care? A review of the theory and evidence with implications for counselling psychologists

Salena Bhanji

Introduction: The current Increasing Access to Psychological Therapies (IAPT) agenda that focuses on the widespread dissemination of CBT in primary care services is considered alongside the emergence of third wave therapies and their role in the treatment of depression.

Review: Theoretical models and empirical outcomes for Mindfulness-based Cognitive Therapy, Metacognitive Therapy, and Acceptance and Commitment Therapy as third wave treatments for depression are examined with implications for how mindfulness approaches can be integrated into the therapeutic work of counselling psychologists (CoPs).

Conclusion: Further theoretical and empirical considerations for the inclusion of third wave therapies into the IAPT agenda are discussed with suggestions for further research.

Keywords: depression; third wave therapies; mindfulness; primary care.

Depression is one of the most common presentations for consultation in primary care throughout the UK on the grounds of its ubiquitous nature and susceptibility to relapse and recurrence (NHS Centre for Reviews and Dissemination, 2002). The current paper challenges the guidelines set out by the National Institute for Health and Clinical Excellence (NICE) that focus almost exclusively on cognitive behavioural therapy (CBT) to treat depression in primary care services. It proposes that perhaps it is time for the current paradigm to shift so that other viable treatments for depression could be included in NICE, in particular ‘third wave’ or mindfulness based therapies. Despite their comparatively limited research base with its corresponding share of criticisms, the present paper draws attention to their promise as empirically-supported alternatives to CBT in the treatment of depression.

At present the Improving Access to Psychological Therapies (IAPT) agenda funded by the UK National Health Service (NHS) promotes the delivery of CBT in primary care trusts for the treatment of mild to moderate depression and anxiety (Department of Health, 2008). The development of IAPT was influenced significantly by Layard’s (2005) report on happiness that documented the detrimental effects of depression and psychological problems on society and the economy. IAPT was also established in line with NICE guidelines for depression (NHS, 2009) that are underpinned by numerous trials demonstrating the efficacy of CBT compared with antidepressant medications (ADM), waiting list controls or placebo treatments (e.g. Butler et al., 2006; Evans et al., 1992; Shea et al., 1992) and in the prevention of relapse and recurrence compared with ADM (e.g. Gloaguen et al., 1998; Hollon et al., 2005). Importantly for the current argu-
ment however, the empirical base which supports the existing IAPT focus on CBT has not been extended to the third wave therapies and as such the Be Mindful report (Halliwick, 2010) notes the considerable absence of mindfulness from the IAPT agenda.

A number of criticisms have been sounded about the IAPT endeavour. McPherson, Evans and Richardson (2009) question whether IAPT has a sound evidence base for producing change in quality of life and functioning rather than producing symptom change alone, whilst many other mental health practitioners (e.g. Rogers, 2009) have raised disconcerted voices regarding the status of CBT as a national panacea (see also debate between Professor Andrew Samuels and Dr David Veale, 2007).

In addition, the proponents of CBT are being increasingly challenged. In a review of CBT evidence, Gaudiano (2008) stated that CBT is considered an overly mechanistic approach that fails to address the issues of the whole person. It’s also been stated that CBT as it is normally practiced may not be suited to people from non-Western cultures (Naeema et al., 2009) nor for people who are less psychologically minded (Whitfield & Davidson, 2007). Some studies have failed to demonstrate that the processes of CBT actually operate in accordance with the model (Burns & Spangler, 2001) and in other studies the specific cognitive components of CBT have failed to outperform basic behavioural strategies (e.g. Jacobson et al., 1996; Gortner et al., 1998). However Ost (2007) notes that studies which dismantle the separate parts of CBT actually disable its effectiveness which lies in the amalgamation of cognitive and behavioural techniques. Several anomalies have also been identified in CBT studies including improvements in symptoms that do not logically follow from the implementation of cognitive techniques and inconsistencies in how assumed cognitive mediators (e.g. thoughts, assumptions) function in accordance with the cognitive model (e.g. Dobson & Khatri, 2000; Ilardi & Craighead, 1994). A core tenet of CBT is also being questioned, with many asking the inevitable question – do we really need to change the content of thoughts as CBT suggests? (Longmore & Worell, 2007).

Thus follows the burgeoning interest in third wave therapies that embrace a mindful and acceptance-based approach to mental health, based upon principles emanating from Buddhist philosophy and spirituality (Baer, 2003). Mindfulness has been defined as ‘paying attention in a particular way: on purpose, in the present moment, and non-judgementally’ (Kabat-Zinn, 1994). Hayes (2004) coined the term ‘third wave’ therapies to distinguish between the pure behaviourist approach of the first wave, the addition and dominance of Beck’s cognitive therapy in the second wave and the focus on mindfulness and acceptance based interventions in the third wave. One of the key differences between second wave and the third wave CBT is the shift from changing the content of thoughts to the focus on changing how one relates to, observes or processes their thoughts (Hayes, 2004). According to Hayes (2004), the third wave therapies include Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1994), Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2002), Metacognitive Therapy (MCT; Wells, 1995), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999), Dialectical Behaviour Therapy (DBT; Linehan, 1993), Functional Analytic Therapy (FAP; Kohlenberg & Tsai, 1991) and Cognitive Behavioural Analysis System of Psychotherapy (CBASP; McCullough, 2000) among others. Several reviews have been conducted to evaluate the existing evidence for these therapies. Coelho et al. (2007) reviewed the studies of MBCT, Ost (2007) conducted a meta-analysis of all third wave therapies with the exception of MBSR, MBCT and MCT, Hayes (2004) examined the empirical evidence supporting ACT, DBT and FAP and Wells (2008) provided a summary of the research in MCT. These reviews have revealed that the therapies which have been trialled in some way for the
treatment of depression include MBCT, MCT, ACT, DBT, FAP and CBASP, however, there has not as yet been an attempt to review the research evidence for third wave therapies that have focused exclusively on their efficacy for depression.

To keep this article comprehensive, the focus is narrowed to three third wave therapies that offer somewhat more research in this field based on the current literature, namely MBCT, MCT and ACT. Ost (2007) notes that Adrian Wells doesn’t necessarily consider MCT to fall under the umbrella of third wave therapies, seeing it as rather an extension to CBT, however, it has been included in the review based on its therapeutic convergence with the third wave focus of shifting away from direct efforts to change first order cognitions (Hayes, 2004). DBT was also excluded as it was specifically developed for use with borderline personality disorder (BPD) patients and only two studies were available that linked DBT with depression. Therefore, the aims of this article are to firstly recapitulate the theoretical underpinnings and existing research on these three therapies; secondly, to provide reviews of studies that have not yet been included in any of the major reviews to date; and thirdly, to reflect on the implications for CoPs using mindfulness therapies to work with depression in primary care.

Mindfulness-based Cognitive Therapy
Mindfulness-based Cognitive Therapy (MBCT) was developed to reduce the risk of relapse and recurrence of depression by teaching patients who have recovered from episodes of depression to recognise and disengage from negative and ruminative thinking (Teasdale et al., 2000). MBCT is an eight-week, class-based programme that combines mindfulness training from Kabat-Zinn’s (1990) Mindfulness-based Stress Reduction (MBSR) programme with aspects of traditional cognitive-behavioural therapy (Segal, Williams & Teasdale, 2002). Although both MBCT and CBT focus on gaining a greater awareness of thoughts and feelings, MBCT is dissimilar to CBT in that it does not emphasise changing the content of thoughts but rather changing the relationship to inner experiences. Teasdale (1999) highlights the importance of facilitating metacognitive insight in order to change this relationship. The experiencing of one’s awareness that thoughts are transient events in the mind is considered by Teasdale (1999) to be more potent in the prevention of depression than metacognitive knowledge, or the factual understanding that thoughts are not reality. This distinction is contextualised within a cognitive framework initially developed by Barnard and Teasdale (1991) and referred to as the Interacting Cognitive Subsystem (ICS). The ICS uses mental codes that represent distinct qualities of experience and meanings of experience. Propositional codes refer to specific meanings with a truth value whereas Implicational codes are linked to more implicit or intuitive meanings that cannot be evaluated but can directly impact on emotional states. According to Teasdale (1999) vulnerability to persistent depression and relapse occurs through a ‘depressive interlock’ (p. 150) that involves the circular processing of Implicational ‘depressogenic schematic models’ and Propositional meanings, which are negatively self-focussed and ruminative in nature. Teasdale et al. (2000) notes that MBCT teaches depressed individuals to observe the content of their thoughts and then detach from them using their breath as an anchor. Mindfulness practice thus facilitates moment-to-moment metacognitive insight and cultivates a ‘being’ mode that is cognitively distinct from the depressive interlock (Teasdale, 1999). However, as depression can often limit a person’s concentration and motivation to engage in active learning, RCTs of MBCT have so far been delivered to depressed patients in a remitted state (Baer, 2003).

Teasdale et al. (2000) conducted the first RCT that compared MBCT plus treatment as usual (TAU) with TAU alone on recovered patients (N=145) with a history of two or more recurrent episodes of major depression disorder (MDD) and considered to be
at risk of relapse or recurrence. Their results showed that for patients with three or more previous episodes, significantly lower relapse hazard rates were reported for the treatment condition compared to TAU alone whereas there was no significant difference between groups for patients with two previous episodes. Ma and Teasdale’s (2004) wanted to replicate the relapse prevention effects of MBCT observed by Teasdale et al. (2000) and to explore the reasons for the differential response to MBCT in the group of patients with only two episodes of MDD. Their results did replicate the earlier findings and it was indicated that the differential response could be because the patients with two previous episodes came from a different base population characterised by normal childhood experiences, later initial onset of major depression and relapse/recurrence predominantly associated with major life events as opposed to internal cognitive processes. Williams et al. (2000) conducted an RCT in which they compared a MBCT plus TAU with a TAU only group on changes in mood and autobiographical memory on the basis that overgeneral categoric memory was thought to be common in depression and likely to contribute to the problem-solving deficits seen in depressive disorders. The results indicated that the MBCT plus TAU group experienced a greater shift away from overgeneral memories and a greater increase in specific memories (Williams et al., 2000). Lastly a study conducted by Kingston et al. (2007) used a non-randomised design to compare MBCT plus TAU with TAU alone for the treatment of residual depressive symptoms. The results indicated that the pre- and post-treatment scores on the BDI scale were significantly different in the treatment group compared to the TAU only group but that there were no significant differences between groups in changes on a rumination scale.

These four studies were reviewed by Coelho et al. (2007) who identified several limitations. Firstly, the trials only compared MBCT plus TAU with TAU alone, therefore, there is no evidence to indicate that the specific effects of MBCT were responsible for the improvements. Secondly, there is no reference made to the nature of TAU and what role this may play in the trials. And thirdly, these studies do not describe randomisation procedures or provide reasons for withdrawals or drop-outs by group. Baer (2003) also points out that many of these studies do not describe the procedures used to train therapists or to evaluate their delivery of mindfulness treatment and the experiences of therapists delivering the treatment is not always clarified. Furthermore Teasdale et al. (2003) noted that in the Teasdale et al. (2000) and Ma and Teasdale (2004) trials, patients with two previous episodes of MDD showed a non-significant but greater tendency to relapse following MBCT than those who continued with TAU indicating that mindfulness training may be unhelpful for some people, perhaps by streaming attention to negative thoughts that would ordinarily be diverted elsewhere.

These studies have primarily focused on the therapeutic outcomes of MBCT in treating depression. However three studies which utilised qualitative methods and which have not yet been reviewed, explore the therapeutic processes involved in MBCT.

In Mason and Hargreaves’ (2001) qualitative study, seven participants in total were interviewed at two stages. Initially four participants were interviewed a few weeks after participating in the MBCT course and then a further three were interviewed having completed the MBCT programme 12 to 30 months earlier. All participants conformed to the DSM-III-R criteria for depression on at least two occasions. Researchers used grounded theory to analyse the interviews and identified distinct categories of phenomena relating to therapeutic process. Researchers concluded that initial expectations were important in later insight and practice of mindfulness techniques, i.e. those with open and flexible expectations described fewer barriers and initial negative experiences than those with rigid and highly optimistic
ones. Other themes that seemed key in the process of change included changes in attitude, the support of the group, generalisation of skills to situations of everyday living and engaging in therapeutic ‘homework’.

The ICS model presumes that MBCT interventions should allow depressed individuals to experience mild negative effect without the depressive thoughts ‘taking over’ and producing the depressive interlock. In accordance with the model, some participants’ statements illustrated how they had a conscious awareness that they were being bothered by thoughts that they couldn’t eliminate, but that acknowledging them took away their power leaving participants with a sense of control.

Finucane and Mercer (2006) used a mixed-methods design in which patients (N=13) from a single primary care practice, who had current symptoms of depression as well as at least two previous episodes of depression as indicated on Beck’s Depression Inventory (BDI-II) took part on a slightly modified version of the eight-week MBCT programme. A thematic-based analysis of semi-structured interviews indicated that the chronicity of depression and a wish to avoid medication were key motivating factors for people to participate in the programme. Secondly, being in a group was experienced as an important normalising experience for several patients (e.g. ‘I’m not a nut… I’m just an ordinary… person’) and instrumental in helping people persevere with some of the exercises. Thirdly, whilst some people were able to do the specific MBCT exercises for homework, others tried to practice mindfulness whilst ‘washing the dishes’ or ‘walking the dog’. Several patients however did report difficulties in motivating themselves to continue practicing once the course had ended.

Allen et al. (2009) used qualitative methods to determine participant’s experiences of MBCT as a relapse prevention treatment. The major themes from the study included an enhanced feeling of control over depression, an acceptance of thoughts and feelings associated with depression, a sense of expressing and meeting personal needs in relationships and the identification of a range of struggles with MBCT. Allen et al. (2009) also cited Ma’s (2002) unpublished PhD dissertation that used IPA as a qualitative approach to explore the experience of individuals a year after completing a MBCT course. The results revealed several themes pertaining to change, i.e. in relation to depression, relationships, and life in general (e.g. feeling empowered and confident). Another theme related to receiving support from the group (e.g. being understood).

Overall, the qualitative research that is reviewed here, indicates that MBCT comprises an amalgamation of therapeutic processes that may be effective for the treatment of active depression. The processes of MBCT appear to be mediated most meaningfully by the client’s: (1) expectations and motivations; (2) ability to internalise the core skills of mindfulness; (3) desire to engage in attitude modification; (4) responsiveness to group based therapies; and (5) willingness to undertake therapeutic homework. A noteworthy finding is that the chronicity of depression was a highly motivating factor to partake in the therapy. Qualitative research does not allow generalisation from findings; however, the findings do provide useful direction for further research into the active processes of MBCT, i.e. is it in the therapy itself or is it in the context of the group format or is it the relationship with the therapists/researchers? In addition, some researchers showed how the theoretical processes of MBCT could be supported by the ICS framework and demonstrated the long-term usefulness of MBCT after a longer follow-up period than previous studies have tested.

Considering both the previously reviewed quantitative research and the qualitative research findings reviewed here, it can be tentatively concluded that for a health care system that is already over-stretched on resources (Scherer-Dickson, 2004), MBCT may provide an advanced and cost effective treatment being that it is a group-based
therapy that has achieved results with relatively inexperienced facilitators. NICE guidelines for depression in adults (NHS, 2009) already recommend MBCT as a relapse prevention treatment for individuals who are currently in remission and have experienced three or more episodes of depression, however Halliwick (2010) stated that the infrastructure needed to establish MBCT groups is limited and as a result MBCT is not available in many areas of the UK. This review thus adds further weight to calls for making MBCT more available as a treatment for adults with recurrent depression and for more research to investigate whether MBCT programs could be adapted for people with current symptoms or at least two episodes of depression.

**Metacognitive Therapy**

Although metacognitions feature prominently in MBCT, metacognitive therapy (MCT) is more interested in the beliefs that modify the ways in which thoughts are experienced and regulated (Wells & Purdon, 1999). The most significant difference between CBT and MCT in addressing rumination, which is one of the key processes believed to lead to depression (Nolen-Hoeskema et al., 1993), is that CBT tends to focus on the content of rumination whereas MCT focuses on the content of the metacognitive belief regarding rumination. Two types of metacognitive beliefs are implicated: (1) positive beliefs about the need to worry and ruminate; and (2) negative beliefs about the uncontrollability of these thoughts (Papageorgiou & Wells, 2000). Wells (2000) was critical of ICS framework that underlies MBCT and states that one of its greatest limitations is that it is difficult to define the concept of implicational meanings and substantiate its position in the information processing context (Scherer-Dickson, 2004).

MCT was, therefore, founded upon an alternative theoretical framework entitled the self-regulatory executive function model (S-REF; Wells & Matthews, 1994) that is believed to overcome the limitations of the ICS model. In a condensed explanation, the development of emotional disorders is attributed to the presence of maladaptive ‘self-regulating’ metacognitive beliefs rather than the triggering of depressive interlock via implicational meanings. Consistent with the third wave therapies, MCT presents the idea that treatment should integrate CBT techniques such as questioning the evidence and behavioural experiments to challenge the metacognitive belief instead of the negative automatic thoughts (Wells, 2008). Other techniques that MCT therapists use to challenge both positive and negative metacognitive beliefs includes attention training (Wells, 1990), detached mindfulness (Wells & Matthews, 1996; Wells 2005) and situational attentional refocusing (Wells & Papageorgiou, 1998). So far, studies have predominantly tested aspects of the metacognitive model in relation to depression and rumination (Wells, 2008). The results have shown that positive metacognitive beliefs about rumination have been found to correlate with higher levels of self-reported rumination (Watkins & Baracaia, 2001) and with depressive symptomology (Papageorgiou & Wells, 2001a, 2001b).

Wells et al. (2009) conducted the first study using a full MCT package for depression in an attempt to bridge this gap in research. Theirs was a multiple-baseline study whereby four participants with a primary diagnosis of major depression were randomly assigned to four baseline conditions in which their degrees of rumination and levels of depression and anxiety were measured on a weekly basis. Positive and negative beliefs about rumination and metacognitions were also assessed. Results were that patients showed large and clinically significant improvements in depressive symptoms in addition to rapid and substantial reductions in the extent of their rumination. Also, both positive and negative metacognitive beliefs decreased substantially during treatment and the unhelpful attentional style of focussing excessively on thoughts also decreased. The researchers concluded that this study provides encour-
agging results suggesting that MCT might be an effective brief treatment for depression.

With the origination of MCT occurring over 10 years ago, it is somewhat surprising that the first study incorporating the therapy in its entirety for such a prevalent disorder has come at such a late stage. The study controlled for the confounding effects of maturation, exposure to the clinical setting, and repeated testing, utilised several outcome measures and incorporated a relatively longer follow-up period (six months). However, in addition to the small sample size ($N=4$) and absence of control conditions, the authors noted that there was no formal assessment of adherence to the treatment manual and that the assessor was not blind to the presence or absence of treatment which could have influenced the assessor’s ratings. Also they could not determine the impact that therapist expectations might have had on rumination measures as the measures had not been validated in this regard.

Since Wells’ initial study, three additional studies have been published using MCT for depression. Nordahl’s (2009) study aimed to assess the effectiveness of brief MCT compared to CBT in a sample of patients who had previously failed to respond to medication. Improvements were observed for patients with depression in both conditions, suggesting that MCT can be as effective in treating depression as CBT in brief treatment settings. Wells (2009) tested the relationship between negative metacognitive beliefs, rumination and depression to investigate possible causal factors in the MCT model. In line with the MCT model, negative metacognitive beliefs about rumination could predict depression even when initial levels of depression and rumination were controlled, however, rumination did not predict depression when negative metacognitive beliefs about rumination were controlled. Moulds et al. (2010) conducted a similar study to examine whether positive metacognitive beliefs increase vulnerability to rumination. Participants with high levels of positive beliefs reported more rumination following negative, positive or no feedback on a stressor task compared to participants with low levels of positive metacognitive beliefs, which was also consistent with the MCT model.

The present review suggests that while the research conducted to date is still limited and may be methodologically flawed, that nonetheless there is accumulating evidence supporting the theoretical model underlying MCT and that the evidence so far indicates that MCT is a promising alternative to traditional CBT as a treatment for depression.

**Acceptance and Commitment Therapy**

Acceptance and Commitment Therapy (ACT) is another of the third wave therapies with some research that has clinical implications for the treatment of depression. As noted in Hayes (2004), ACT was developed from a philosophy called functional contextualism that focuses on influencing psychological events by acting effectively within a specific context, and has its conceptual roots in Skinner’s work on verbal and rule-governed behaviour that came to be known as radical behaviourism. Functional contextualism underpins a theory of language and cognition that ACT is based upon, which is referred to as Relational Frame Theory (RFT; Hayes et al., 2001). RFT puts forward the notion that relational frames are constructed associations that are formed between words and events when a person engages in verbal and cognitive processes (Hayes, 2004). It suggests that the clinical goals of ACT in respect to depression, are to erode the control that the literal verbal content of the depressive thought (e.g. ‘I am hopeless’) can have on behaviour (e.g. lying in bed all day) and instead create an alternative context whereby the initial thought can give rise to behaviour that falls in alignment with the depressed person’s life values (Hayes, 2004). ACT implements many techniques similar to traditional cognitive therapy, however it does not seek to correct these unrealistic or irrational thoughts through cognitive restructuring. Instead
ACT uses mindfulness and acceptance based tools to teach the depressed person to embrace a non-judgemental approach to their depressogenic thoughts in order to diminish their believability, reduce negative self-talk and induce positive and constructive behaviour (Hofman & Asmundson, 2008).

Two early studies used comprehensive distancing (CD) as an earlier version of ACT with CD and ACT sharing the common goal of weakening dysfunctional control (Zettle, 2005). In the first RCT, Zettle and Hayes (1986) conducted a small study (N=18) in which depressed women were randomly assigned to a twelve-week course of either CD or Beck’s (1979) cognitive therapy for depression, with treatment delivered in an individual format for both groups. Results revealed that CD produced significantly greater reductions in depression when compared to CT at the stage of post-treatment and at two month follow-up. A subsequent RCT carried out by Zettle and Rains (1989) with depressed women (N=31) compared treatments across three groups including one CD and two CT groups, with and without cognitive distancing. Results showed significant yet equivalent reductions in depression for all three treatment conditions at post-treatment and at two-month follow-up, which was thought to have resulted from the administration of CD in a group context. However significant reductions in the believability of depression-related thoughts were only found for the CT groups suggesting that CD and CT functioned through different therapeutic processes, i.e. CD worked through behavioural rather than cognitive processes. Whilst these studies are important in having directly compared ACT in its earlier form with CT, they aren’t without their methodological flaws including small sample sizes, short follow-up periods and the lack of systematic diagnostic procedures for depression (Hayes et al., 2006). Despite these critiques, the results do hint at the effectiveness of ACT as a theoretically distinct alternative to CT in the treatment of depression.

Thus it is surprising that there has been a lag in further research of this area until Forman et al. (2007) conducted a randomised controlled effectiveness trial comparing the relative effectiveness of CBT and ACT in the treatment of patients presenting with anxiety and mood disorders in an outpatient clinic. The results showed that although there were significant reductions in depression and anxiety in the 101 participants, there were no significant differences by treatment for any of the outcomes that were assessed, demonstrating that the rate and degree of patient improvement over time appeared equal across the two treatment approaches. The results however were consistent with the researcher’s predictions in that participants in the CBT group were better able to identify and describe changes in their inner experiences whereas acting with awareness and acceptance was more strongly seen in the ACT group, supporting their premise that ACT and CBT operate using different processes. A more recent RCT carried out by Bohlmeijer et al. (2011) investigated the efficacy of ACT compared to a waiting list control as an early intervention for adults with mild to moderate depressive symptoms. Participants in the ACT group experienced significant reductions in depressive symptoms after the intervention and three months post intervention with improvements in acceptance in the intervention mediating the effects of ACT on depression at the three-month follow-up. And an unpublished study conducted by Folke and Parling (2004) applied ACT in a group format with individuals who were unemployed and on sick leave suffering from depression. Participants in the ACT group showed significantly lower levels of depression and reported higher scores on quality of life, general health and perceived functioning compared to participants who received public service interventions.

The strength of the first study was the direct comparison of ACT with CBT which supports the notion that ACT is at least as effective as CBT in treating depression (and
anxiety) disorders. The research design incorporated checks on adherence to the therapy and controlled for therapist allegiance, however, the sample size was modest, the rate of attrition high and there were no design controls for the overlap of therapeutic techniques across the two approaches. Importantly for the current argument, the findings are somewhat limited since the study didn’t focus exclusively on depression. The second study shows that acceptance is an active and efficacious longer term feature of the model that can mediate depression. And the last study demonstrates that ACT can be effective in a participant group similar to that found in IAPT, and can improve quality of life in accordance with IAPT’s aims. These studies continue to provide support for the use of ACT as a viable alternative to CBT to treat depression.

Implications for counselling psychologists

There are significant implications for CoPs integrating mindfulness therapies into their work with depression in primary care. Although these inferences can be generalised to other mental health professions working with third wave therapies, considerations are made in light of the profession’s philosophic and therapeutic emphases.

As a starting point, CoPs and third wave therapies seem to share a focus on ‘being’ rather than ‘doing’ with clients (AGCAS Publications, 2006), with doing more closely associated with the CBT approach. CoPs demonstrate this by observing process in therapeutic engagement and reflecting this to the client so that it becomes a source of introspection and insight for both parties. Introducing mindfulness into therapeutic encounters would seemingly allow the CoP to use the process of being with themselves to enhance their ability or willingness for being with their client in all circumstances. This open and meaningful mode of relating seems akin to spiritual connection in therapeutic practice (Sperry, 2001) and would also appear to uphold the spiritual foundations of mindfulness. Many CBT therapists would argue that the collaborative nature of CBT also provides space for the therapist to be with the client in moments of silence and reflection, and that adept CBT practitioners use ‘doing’ techniques (e.g. thought diaries or behavioural activation schedules) to supplement the role of therapy, not replace it. Nevertheless, the notion of spiritual connection would appear to be a foreign entity in much of the CBT literature. This type of therapeutic relationship could also go some way in diminishing the perceived hierarchical structure of professional and client in therapy, offering instead the opportunity for therapy to be experienced as two connected individuals.

Mindfulness has been reported to help individuals develop greater insight, improve problem-solving, enhance attention, lead to less selfishness, greater acceptance, greater quality of life and a sense of mind-body integration (Halliwick, 2010). As CoPs are seen to work with individuals who present with a range of mental health problems and developmental issues across the lifespan (NHS, 2009), the holistic focus that mindfulness can offer would considerably serve the profession well. CoPs would be able to facilitate the generalisation of effects from mindfulness for depression to other spheres of the individuals’ life such as difficulties in relationships and physical health problems that are prevalent issues in primary care settings. Furthermore the capacity for CoPs to work integratively (NHS, 2009) means that mindfulness can be applied alongside other therapies in a formulation driven approach to best serve the interests, needs and cultural context of the client. These effects resonate with the ‘prevention is better than cure’ adage and implicate prospective reductions in the financial impact of relapse and recurrence in primary and secondary mental health services and the promotion of longer term benefits to society if primary care patients are offered mindfulness as an early intervention to develop alternative ways of responding to difficulties and enhancing their quality of life in general.
Kabat-Zinn (2003) advocates strongly for mindful practitioners to have a personal practice of mindfulness themselves, which if adopted by CoPs could be experienced as personally fulfilling particularly as an adjunct to the emphasis placed on ongoing personal development through personal therapy. It may also enhance the resilience of CoPs to professional burnout and may serve a harmonising function whereby CoPs can experience first-hand how mindfulness practice can generalise across different areas of life and achieve a sense of ‘practicing what they ‘t’each’.

Conclusions
This paper began with a critique of the almost exclusive focus in IAPT on CBT and the disregard of so-called third wave therapies. This review is cautiously optimistic in contrast with other voices that question whether these therapies can justifiably be considered a new wave of CBT (Hofman & Asmundson, 2008) and are actually empirically supported (Corrigan, 2001).

However, this review also makes it clear that further empirical evidence is required. Several researchers have underlined the need to compare therapies more rigorously with control groups or similar group treatments (e.g. Coelho et al., 2007) and other researchers suggest that it would be valuable to use qualitative measures to address how individual differences in mindfulness develop naturally and identify what psychological and social conditions support and hinder its development (Brown & Ryan, 2003). It would also be interesting to conduct a large-scale mixed-methods study comparing the third wave to CBT, antidepressant medication and a waiting list control. If treatments were adapted to the 12 to 18 session structure offered in high intensity IAPT services and carried out in both individual and group formats to primary care patients with depression, this would allow researchers to compare specific mediating factors, therapeutic processes and efficacy across a range of early intervention treatments. Two other areas that could greatly improve research in this field is the development of valid measurement tools and investment in neuropsychological testing (Singh et al., 2008).

Despite this long ‘to-do’ list, it is the argument of this paper that CoPs should welcome the fact that findings that support third wave therapies as viable treatments for depression seem to be growing steadily. And with most promise, the growth of mindfulness-based therapies have meant that the universal human themes of spirituality, values, and acceptance are being embraced in a way that was uncommon or even unwelcome before.

About the Author
Salena Bhanji is a third-year trainee on the Counselling Psychology Doctorate at City University London. Having completed a significant proportion of her trainee placement experience in primary care IAPT settings, she has developed a keen interest in mindfulness-based therapies for depression and anxiety and aims to make a professional investment in contributing towards the proliferation of research in this field.

Correspondence
Salena Bhanji
City University London,
School of Social Sciences,
Northampton Square,
London EC1V 0HB.
Email: salena.bhanji.1@city.ac.uk
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*Is it time we turn towards ‘third wave’ therapies…*
Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: A discussion of cognitive behavioural therapy, mindfulness, and mindfulness-based cognitive therapy

Jennifer Ellen Dayes

Content and Focus: This article explores the acceptability and usefulness of cognitive behavioural therapy, mindfulness, and mindfulness-based cognitive therapy for people with Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS). Issues specific to researching this particular group are discussed also. Both peer reviewed literature and surveys from support groups are considered.

Conclusions: The article argues that mindfulness and mindfulness-based cognitive therapy – an integration of mindfulness and cognitive therapy – may be acceptable and beneficial to people with ME/CFS. Particular advantages lie in a flexible and cost-efficient application. The author concludes that further research into mindfulness and mindfulness-based cognitive therapy is warranted in this population. The article also highlights that a representative sample of people with ME/CFS is difficult to generate, and that findings can be hard to generalise.

Keywords: myalgic encephalomyelitis; chronic fatigue syndrome; cognitive behavioural therapy; mindfulness, mindfulness-based cognitive therapy.

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) affects approximately 250,000 people in the UK. The key symptoms are fatigue brought on by activity, cognitive dysfunction, and pain, sleep and mobility problems (The ME Association, 2010). This article focuses on three therapeutic approaches for ME/CFS; cognitive behavioural therapy (CBT), mindfulness, and mindfulness-based cognitive therapy. Areas of interest for future investigation are explored, and potential problems in researching this population are highlighted.

ME/CFS is an illness surrounded by controversy. Stalmeisters and Brannigan (2011), highlight that this may be due to a lack of biological clarity. Indeed, Shepherd and Chaudhuri (2009) explain that the cause of ME/CFS is not yet fully understood, numerous diagnostic criteria are in use, and no set treatment has been established. As a result, some researchers argue that the biomedical status of ME/CFS has been delegitimised (Stalmeisters & Brannigan, 2011). Richman et al. (2000), as cited in Stalmeisters and Brannigan (2011), explain that this failure to validate a viral aetiology has perhaps led to ME/CFS being understood as a psychological illness. However, ME/CFS is not psychologically based, and is currently classified as a neurological condition by the World Health Organisation (International Classification of Diseases 10, G93.3).

The National Institute for Clinical Excellence advises CBT for everyone with mild-moderate ME/CFS (NICE, 2007). However, there is debate about whether CBT is a suitable therapy for this condition. One adverse argument is that CBT undermines the
neurological aetiology of ME/CFS because it traditionally understands distress as resulting from maladaptive thought patterns. This application is found unacceptable by many of the ME/CFS population. Participants in a study conducted by Ward et al. (2008) reported that they viewed counsellors subscribing to a psychological model of ME/CFS with negativity and suspicion. Clients were particularly concerned when CBT was presented as a cure. They viewed this as patronising, simplistic, controlling and brainwashing (Ward et al., 2008). Support organisations seem to promote a similar view. When the current ME/CFS NICE guideline was published with a strong CBT focus, the ME Association argued its advice advocated a psychosomatic model. The Association, therefore, states the guideline is ‘completely unfit for purpose’ (The MEA, 2007, p.1).

It appears, however, if counsellors clearly accept that symptoms have a genuine physical basis then CBT is considered acceptable by the ME/CFS population (Ward et al., 2008; Shepherd & Chaudhuri, 2009). Indeed CBT has been found beneficial for ME/CFS. Clients appear to find this approach useful when it focuses on helping them cope with, or manage, their illness. For example, some clients in the study by Ward et al. (2008), found CBT very useful to help counter unrealistic or catastrophising reactions. Similarly, in research by Bleijenburg, Prins and Bazelmans (2003), participants found CBT useful to find an optimal level of activity, a finding that could mean substantial decreases in activity.

Despite these positive results, it is important to highlight that other research reports CBT could be dangerous for those with ME/CFS. A survey by Action for ME reported that in 67 per cent, CBT elicited no change. Twenty-six per cent felt symptoms had worsened (AFME, 2001). In a more recent survey, 54 per cent of respondents described no change in symptoms, and 19 per cent felt worse afterwards (The MEA, 2010).

There are other problems concerning the application of CBT to ME/CFS. The MEA (2010) explain that CBT is mainly carried out at specialist centres or local hospitals. Sessions may, therefore, be hard for a number of patients to travel to due to the nature of symptoms. As a result of cognitive dysfunction, it is probable that many would have difficulty concentrating in sessions. Homework may also be troublesome. Moreover for some, travelling to sessions, concentrating whilst in them, and keeping up homework could do more damage than good. This is because, as explained by Shepherd (1998), symptoms are often triggered by activity. The effect of activity on symptoms can be troublesome because often individuals find it difficult to judge exactly how much activity might elicit/exacerbate symptoms (Shepherd, 1998). Additionally, NHS waiting lists for CBT are long (Surawy, Roberts & Silver, 2005). Private sessions are often costly, hence not feasible for many people with ME/CFS on a reduced income, or living on benefits.

An alternative management approach could be that of mindfulness. Mindfulness therapy might be described as a combination of science and meditation (Williams et al., 2007). It is the art of awareness, reached by paying purposeful attention in the present moment without judgement (Williams et al., 2007). It appeared in Western psychotherapy in the 1970s (Whitfield, 2006), becoming increasingly popular in recent years. Presently, there is much research being undertaken into mindfulness, and some into mindfulness-based cognitive therapy (MBCT) – an integration of mindfulness and cognitive therapy. There are also mindfulness courses running specifically for people with ME/CFS throughout England. However, research into mindfulness and ME/CFS is scarce. In fact, this author has found only one published paper.

From current research, it appears that mindfulness, and related practices such as meditation and relaxation, are extremely acceptable to people with ME/CFS.
et al. (2005) found high levels of acceptability in three separate samples of people with ME/CFS who had attended a mindfulness course. Anecdotal reports are also complimentary. One individual reported in InterAction, the magazine published by Action for ME, ‘mindfulness totally transformed the way I dealt with ME and gave me the ability to find some calm and happiness in my life’ (Anon, p.37). 53.7 per cent of respondents to the ME Association’s survey reported that meditation and relaxation techniques improved symptoms. Furthermore, respondents rated these least likely to make symptoms worse (The MEA, 2010). Similarly, there is no mention of negative effects of mindfulness on ME/CFS in Surawy et al. (2005).

Research shows beneficial effects of mindfulness on the five symptoms rated most severe by respondents to the ME Association’s survey. These are muscle fatigue, cognitive dysfunction, pain, sleep problems and mobility problems (The MEA, 2010). Surawy et al. (2005) found significant improvements in fatigue in people with ME/CFS after an eight-week mindfulness course. Improvements were maintained at three-month follow-up. Although the effects of mindfulness on cognitive dysfunction, pain, and sleep problems appear not to have been researched in an ME/CFS population, benefits have been found in other samples. For example, Zeidan et al. (2010) found brief mindfulness training improved visuo-spatial programming, working memory, executive functioning and ability to sustain attention in university students. Rosenzweig et al. (2010) found mindfulness to reduce pain intensity and limitations caused by pain in patients with arthritis, back/neck pain, headache/migraine and fibromyalgia. Shapiro et al. (2003) found mindfulness elicited better quality of sleep in women with breast cancer. Regarding mobility problems, Surawy et al. (2005) found significant positive effects of mindfulness in an ME/CFS sample.

Mindfulness may have further utility to people with ME/CFS in terms of comorbid issues. Shepherd and Chaudhuri (2009) highlight that a quarter of people with ME/CFS experience clinical depression at some point during their illness. Anxiety is also prevalent (Surawy et al., 1995). The benefits of mindfulness in depression and anxiety are well established (Williams et al., 2007), and have been found in an ME/CFS sample (Suwary et al., 2005). For reasons such as the onset of an illness, stigma attached to the illness, and social problems arising as a result of ME/CFS, it is reasonable to assume that stress is commonly experienced. Although this author is unaware of any research investigating mindfulness and stress in an ME/CFS population, studies report beneficial effects in other samples (Agee, Danoff-Burg & Grant, 2008; Dobkin, 2008).

As mentioned earlier, MBCT combines mindfulness with cognitive therapy. It is now used commonly in the NHS, generally in the areas of stress or chronic pain. MBCT has been found useful for symptoms of depression (Mathew et al., 2010), panic (Kim et al., 2010), and anxiety (Evans et al., 2008) among others. It could be that MBCT would work particularly well for ME/CFS. This is because the elements of CBT found useful for people with ME/CFS, can be combined with a potentially useful and highly acceptable management strategy. Findings from Surawy et al. (2005) support this. One of their three mindfulness courses differed from the other two, being based more on an MBCT model. Improvements in this group were wider ranging than the previous studies, eliciting significant positive outcomes on all six outcome measures. Suwary et al. (2005) highlighted that the effect sizes they found were similar to those calculated by researchers in randomised trials of CBT for ME/CFS. It appears therefore, that MBCT has the potential to be as effective as CBT for people with ME/CFS, yet better accepted.

There are further advantages of MBCT for people with ME/CFS, as opposed to a pure CBT approach. MBCT is generally
carried out in groups, making it a lower cost option which reaches more people. Alternatively, MBCT can be practiced at home. Internet-based mindfulness and MBCT courses have been found beneficial for IBS symptoms (Ljotsson et al., 2010) and anxiety (Houghton, 2008) among others. Again this author is unaware of any research investigating internet-based MBCT in an ME/CFS population. Home-based therapy is more accessible to those who find leaving the house difficult. It also means that individuals can practice as little and for as short a time as is appropriate for them. This helps reduce the likelihood that therapy may exacerbate symptoms through over-activity.

In light of the above, this author would argue that more research into mindfulness and ME/CFS is warranted. In particular, further investigation into an MBCT approach for ME/CFS management may prove especially useful. Important areas to focus on would be whether these are acceptable, beneficial and non-harmful management strategies for ME/CFS symptoms.

There are difficulties particular to the ME/CFS population which arise when researching this group. Investigators may therefore benefit from being mindful of the following: Firstly, it appears difficult to get a representative sample. This is particularly true of the under-represented severely affected (The MEA, 2010). For example, only 15 per cent of respondents in the MEA’s study were severely affected, however, this group constitutes approximately 25 per cent of people with ME/CFS (The MEA, 2010). It is probable that many severely affected were unable to fill out the questionnaire – a difficulty potentially relevant to all ME/CFS research using this method. Similarly, those experiencing ME/CFS for less than two years also appear underrepresented. All participants in the MEA’s (2010) report and Ward et al. (2008) had been diagnosed for over two years. Since this appears to be the average diagnostic time (Shepherd, 2005) this issue is likely to be present in many studies. Moreover, many samples (e.g. the MEA, 2010; Ward et al., 2008; AFME, 2001) are recruited from support groups. Although this may be a relatively easy way for researchers to recruit participants, such samples could be biased in favour of those not experiencing full recovery.

Secondly, findings from an ME/CFS population may be hard to draw concrete conclusions from. Ward et al. (2008) highlight that spontaneous remission rates observed in ME/CFS are often close to figures seen in active treatment conditions. This means some reported improvements may not be entirely accountable to intervention. Moreover, the MEA (2010) highlights that several treatments found helpful by some are unhelpful to others. They explain that a wide variation in individual responses to any form of treatment is typical for ME/CFS. This poses a dilemma for investigators researching people with ME/CFS as a common group.

In conclusion, ME/CFS is a controversial neurological illness. Although CBT is currently recommended as the main source of treatment, a literal application of the approach is often met with negativity and has been found harmful. However, CBT can be beneficial if therapists acknowledge the neurological status of ME/CFS and use the approach as a management strategy. Since there are other problems concerned with using CBT in an ME/CFS population, a slightly different approach may be beneficial. Despite literature being sparse, it appears that mindfulness or mindfulness-based cognitive therapy may be particularly useful for both the symptoms and comorbid difficulties associated with ME/CFS. Further advantages of this approach lie in its flexible and cost-efficient application. The use of mindfulness and MBCT in ME/CFS therefore appears worthy of future investigation. Potential issues for future research are difficulties in recruiting a representative sample, and generalising findings.
About the Author

Jennifer Ellen Dayes is a trainee counselling psychologist at City University London.

References


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We are hoping to focus a future edition of Counselling Psychology Review around the above topic. In particular, we would like to publish a wide array of articles covering methodological issues relevant to counselling psychologists. Papers might include philosophical discussion of methodological decision making (e.g. how does quantitative research fit with a profession that prizes rich intersubjective relationships?), particular methodological approaches (qualitative, quantitative or mixed methods), or specific research methods (interviewing, questionnaires, etc.). Alternatively they may reflect upon particular challenges related to the research process that may resonate with the readership of the publication. If appropriate ethical approval has not been sought, these articles should not include case material from client work unless presented as composite cases – please also note that a future special edition of Counselling Psychology Review will focus upon case study presentations.

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Please also remember that Counselling Psychology Review is always looking for new papers in line with its inclusion criteria. This includes original research papers, systematic reviews, case studies (within a research frame) and theoretical articles. Do feel free to submit these at any time in the year.

All the best and we look forward to hearing from you.

Terry Hanley and Elena Gil-Rodriguez  
(please email: terry.hanley@manchester.ac.uk)
Living with Voices: 50 Stories of Recovery
Prof. Marius Romme, Dr Sandra Escher, Jaqui Dillon, Dr Dirk Corstens & Prof. Mervyn Morris

**Reviewed by Amy Dodd**

Based on a substantial number of real-life case stories Prof. Romme and his associates have written what I would describe as a ‘must-read’ in the field of psychosis. As a final year trainee on a counselling psychology doctoral programme I found myself in the exciting but very challenging position of working within a CMHT for the first time and being confronted with clients recounting distressing stories of their psychotic experiences. This book has been an invaluable insight that has both helped to arrest some of my apprehensions and inform my practice with this client group.

The carefully arranged chapters divide what could be an overwhelming topic into digestible and reader friendly sections. Prof. Romme et al. begin with a thoughtful and provocative introduction that discusses the notion of ‘recovery vs. cure’ within the field of voice-hearing and they succinctly review current thinking behind what causes this phenomena. The authors then take the reader on a journey that beautifully explains ways in which voice hearing is an expression of deep distress rooted in the client’s past and what it might represent and be triggered by in the present. They discuss the metaphoric relationship voices often have with different client issues all the while supporting their suggestions with client narratives. The ‘50 Stories of Recovery’ constitute a significant portion of the book and serve to build on the robust foundation the authors have already developed. In conjunction with the preceding theoretical discussion, the first-hand accounts further help to demystify and make sense of the experience of hearing voices and what a meaningful recovery can be.

Amy Dodd
Trainee Counselling Psychologist.
Pluralistic Counselling and Psychotherapy
Mick Cooper & John McLeod

Reviewed by Clare Lennie

If the goal of a book review is to give the readers a flavour of the usefulness of the work to their practice or study, then the associated tasks might be to read and reflect on the writings of the author in order to create a piece of written material for a publication, such as *Counselling Psychology Review*. The methods of undertaking these tasks to ultimately reach the goal might be read the book from cover to cover, dip in and out as the need arises from my work and thinking, discuss with fellow practitioners, apply and consider applications to related fields, follow-up related research materials to understand the location of the work more broadly, consider its applications to practice, reflect on the digestibility of the written material presented and my reactions to it, consider how I might frame my responses in terms of the audience for the book review, decide whether the audience is appropriate to ‘have fun with’ in terms of style of writing, muse, write, refine… and ultimately submit.

The aim of the pluralistic approach to counselling and psychotherapy offered in this text, seems to be a freeing up the practitioner to explore a ‘dialogue of offerings’ with their client, going beyond purist approaches whilst harnessing these ideas within a clear structure of goals, tasks and methods. In the example given above, my thinking is triggered by making me consider all of the different methods that I could employ in undertaking this book review. For example, do I just ‘get the job done’ and read the book, write and submit or do I muse, digest, reflect? Each of these methods has implicit underlying theoretical assumptions which might be driven by the audience for which I am writing. If I allow myself to inwardly digest then presumably I am doing so because I believe that the publication for which I am writing will be interested in my semi digested reflections and musings. If I feel I have to be concrete, structured and authoritative then perhaps this is largely due to the philosophical stance of the journal for which I am writing and what constitutes their and my ideas about truth, epistemological positioning and, ultimately, what is deemed to be publishable.

In terms of the use of *Pluralistic Counselling and Psychotherapy* to training and practice, we have utilised the text heavily in our new Doctorate in Counselling Psychology at the University of Manchester finding the approach to be a useful vehicle from which to free students in inviting them to explore outside of their preferred ‘home base’ of working, whilst maintaining a safety and structure on which to hold. The research informed basis to the approach, with its emphasis on collaboration captures a pluralistic therapeutic training, such as the one at Manchester, in acknowledging that ‘any substantial question admits of a variety of plausible but mutually conflicting responses’ (Rescher, 1993, p.79). In so doing it values the social and political contexts in...
which the profession of counselling psychology has developed and presently positions itself, which is important to us as we support our trainees in preparing for later employment both in and outside of NHS settings. With this in mind the approach advocated by the book views the person seeking support as an active agent of psychological change with whom any intervention should be centred (a ‘dialogue of offerings’). Such a collaborative view values the scientist-practitioner model of professional practice (e.g. Lane & Corrie, 2006) and is increasingly supported by the research exploring the effectiveness of psychological therapies (e.g. Wampold, 2001; Cooper, 2008) again important tenets for us in terms of the integrated and central role that we believe research to play in the development of a counselling psychologist practitioner. The book contains case material, reflections and activities that are helpful in bringing the concepts of pluralism to life and is written in a sensible, grounded and common sense manner that is thoroughly digestible (in line with this, the ‘Therapy Menu’ activity worked a treat with our trainees!).

So, in terms of the extent to which I am able to have fun in this piece, I’ll take a gamble regarding the positioning of Counselling Psychology Review, their editor and readership. If you apply the framework to the goal of achieving an abdominal ‘six pack’, tasks might be to reduce body fat and train the abdominal muscles. Associated methods for reducing body fat could be to lower calorific intake, join a dieting group, not eat after 7.00 p.m., eat fewer carbohydrates, liposuction and to train our abdominals we might do weight training, sit-ups, plank, palates, apply electrical patches…! Each of these methods of fat loss and muscle strength come with their own philosophical positioning as to what constitutes healthy weight loss and muscle training so opening out a ‘dialogue of offerings’ to the client in reaching their goal of the ultimate six pack… Perhaps this is now going just a step too far?

Clare Lennie
Lecturer in Counselling Psychology.

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